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HIV PREVENTION PLANNING COUNCIL

January 15, 1997

The Agenda of this meeting is missing.

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HIV PREVENTION PLANNING COUNCIL
MINUTES OF SPECIAL MEETING WITH DR. MITCH KATZ
January 15, 1997

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Members Present:
Barbara Adler
Ronnie Ashley (Chata)
Hector Carrillo
Gene Copello
Roberto Garcia
Ellen Goldstein
Natalie Gutierrez
Vic Hernandez
Liz Highleyman
Valerie Kegebein
Ana Claire Meyer
Askia Muhammad
Jimmie Naritomi
John Newmeyer
Mark Peppler
Joel Reyna
Maria Rinaldi
Bethsaida Ruiz
Steven Sams
Joshua Volle

AIDS Office Staff:
Kristen Clements
Gene Copello
Michelle Dixson
Lyn Fischer-Ponce
Delia Garcia
Marshia Herring
Mitch Katz
Mark Morewitz
Mike Pendo

Facilitator:
Former HPPC Co-Chair Cynthia Gomez, CAPS

Polaris, Inc./Harder + Co.:
Mary Irvine, Polaris
Lyn Paleo, Harder + Co.

Process Evaluation Team:
Kathleen Roe
Kevin Roe

Guests:
Nick Farrell, CDC
Pat Franks, IHPS/UCSF
Cynthia Laird, BAR
Ann Ueda, Life Institute
Stacy Vogan, STD/HIV Prevention Training Center

1. WELCOME AND INTRODUCTIONS

Ana Claire convened this special meeting shortly after 2:00pm. She explained that there would be no time on the agenda for public comment at this meeting, which had been set aside as a time for Council members to discuss their concerns with Dr. Mitch Katz, Director of the AIDS Office. She briefly introduced Cynthia Gomez of CAPS, who served previously as an HPPC community co-chair, and who would serve as the facilitator for this meeting.

Starting with Cynthia Gomez, all present introduced themselves in a circle around the table and then around the rest of the room.

2. OVERVIEW OF CONTEXT OF MEETING

Kathleen Roe presented for the HPPC Process Evaluation Team. She began by explaining the handouts distributed at the table. She told the group that:

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- the white handout, "HPPC Year 3 Actions Regarding RFP," shows selections from the Chron. Log (updated/distributed by the evaluators) that relate specifically to RFP process;

- the pale yellow (or, for those receiving it in this minutes packet, *bright blue*) handout, "Summary of Key Decisions in Year 3 RFP Process," condenses these RFP-related actions so that they can be scanned more quickly;

- the yellow handout, "HPPC Survey: Preparation for Meeting with Mitch Katz -- Results," reports on the outcome of the member surveys distributed and returned by fax before noon on January 14th;

- the violet handout, "Participant Dialogue," allows for HPPC members' anonymous feedback on the performance of each of the groups involved in the planning process; and

- the green handout allows for non-HPPC members' anonymous feedback on the performance of each of the groups involved in the planning process.

Speaking as the facilitator, Cynthia asked the group present to keep in mind the following general ground rules for the discussion to take place at this meeting:

⇒ respectful engagement;
⇒ active listening;
⇒ hand-raising;
⇒ occasional interruption by the facilitator if speakers should go off-topic or take too much time for their comments; and
⇒ non-participation of the facilitator as a commenter in the discussion (unless she should be asked to comment on something that took place during her tenure on the Council).

Kathleen Roe returned to her presentation, describing this meeting as the first time that the Council has been able to gather and focus on the RFP process alone, without having to take care of other HPPC business items. She said that this meeting was also important because the Council was moving toward the close of a year's work. She then described the Council as having as many different perspectives, goals, expectations, and desired outcomes with regard to this planning process as there are members. Turning to a more specific discussion of the survey results, Kathleen Roe said that, of the 25 members with fax numbers, 17 had returned surveys. She described this as a pretty good response, and added that the results received were then combined and sent back to those respondents whose fax numbers were still accepting faxes. She projected the results (in a more paraphrased, condensed form) on overheads, which covered the following seven question areas:

1) Things You've Done (steps taken, both as a Council member and as a member of your agency and/or community, since the last Council meeting on December 12th)
2) Things We Still Need (documentation or information)
3) Agenda Items (suggestions for areas to cover at this optional meeting)
4) Personal Outcomes (individual expectations from this optional meeting)
5) Council Outcomes (expectations from this optional meeting, for the group)
6) Asked of Council (requests of other members as they prepare for this meeting)
7) Asked of Mitch Katz (requests of Dr. Katz as he prepares for this meeting)

Question and Answer Session with Dr. Mitch Katz

Steven said that, as a new member, he had taken the time to read the entire draft 1997 Plan put out at the end of 1996. Referring to the overheads summarizing Council members' expectations for this meeting, Steven said that the comments about members needing to be accountable to their communities made sense. However, he added that he had a nagging feeling that the decisions of the Council, and the Plan itself, were not reflected in the RFPs or in the funding awards. He expressed a concern about how Council members could be accountable for the results of the RFP and awards processes, given the discrepancies between the Council input and what was implemented. In particular, he wondered why culturally competent agencies had not been funded, and why the points had not been used consistently in determining awards.

As facilitator, Cynthia suggested that the discussion should move forward in the direction of people's questions or comments. She added that changes could be made to the structure of the meeting as it progressed.

Mitch began his comments with a brief introduction. He thanked all of the old members for the work they had done, and thanked the new members for agreeing to serve on the Council. He said that he believed in the Council and in the planning process. He noted that the AIDS Office had begun to do community planning before it was specifically required by the CDC, and that he had been on the panel that created the guidance for the planning effort. He described this guidance as a formalization of what the AIDS Office was already doing, and what would be important for other communities to do as well. He explained that it was very much the goal of the AIDS Office to convene the community process, to receive input on how local services should look, and to carry out that input.

Mitch stated that the past months had been very painful for himself, his staff, and many of the Council members. He expressed his understanding that it is always difficult to make the transition from the stage of planning to the stage of awarding money. He added that it is easier to incorporate a number of different ideas and values into a Plan than it is to carry out all of those ideas and values, which sometimes turn out to be in competition with one another, when it comes to actual awards. He stressed that there are some difficulties that arise any time you have to award funding, and that dollars are not values -- although dollars are important for doing the work that providers believe in doing. He stated that it was not a coincidence that the toughest times for the Council had happened around the awards process, which he described as inherently difficult. He added that the issues raised in members' comments about ethnicity and culture were painful for him as well as for the members. He explained that, when the Plan came out, it looked surprisingly different from the model by which the AIDS Office had generally allocated funding in the past. The previous model relied on smaller, more narrowly-defined categories: risk group, gender, ethnicity, and sometimes neighborhood. While there were often questions from providers and the larger community about whether the AIDS Office had put the right amounts of funding into each category, the older model did not require funding decisions to be made across ethnicities, genders, geographic areas, or service modalities. Dr. Katz went on to say that, in hearing the guidance of the Plan, his first instinct had been to doubt that the AIDS Office would be able to implement it successfully. He had wanted, instead, to hear the specific items that the HPPC would like to have changed -- where to put more money and where to put less, by intervention type and by group served. He had felt that that kind of input could be more easily implemented by the AIDS Office. However, the HPPC vision was too boldly different to be fitted to the narrower, earlier model of funding allocation. Rather than needing slight revisions in particular areas, the system of funding

allocation was due for a complete overhaul, which the HPPC outlined in the Plan. Dr. Katz added that RFPs are imperfect vehicles for realizing a vision. He said that, despite the difficulties of implementation, he understands why the Council felt its Plan was best.

Speaking to the outcome of the RFP and awards processes, Mitch Katz said that he thinks the collaborative planning process achieved a great deal. He agreed that the funding was not all the way it should be, but he added that the current distribution of funds does not resemble the kind of distribution that would have been achieved if it had been handed down from Mitch Katz as dictator. He explained that he has his own disagreements with the final awards, but that he feels the AIDS Office did the best it could to implement the vision of the HPPC. He added that the AIDS Office would be better equipped to implement the HPPC's vision in the future, and that it was already better equipped to do so now. With reference to the gaps in services, Mitch Katz said that it should not surprise anyone that the RFP and awards processes had not managed to fill all of the gaps, given that there was no increase in the funding for prevention. He said that the amount available simply was not sufficient; so that there were gaps before this planning process, and gaps remain. In his view, no Plan or distribution of services could have succeeded in meeting every need in every group, with the existing funding. He said that he didn't think that, because there were still service gaps, people should conclude that the planning process had failed. Instead, he pointed to the limitations of any system relying on finite resources.

Referring to a tension in the planning process that led to some difficulties for implementation, Dr. Katz said that he had noticed in meetings and in minutes the competing interests of the Council in supporting experience and supporting "new blood" (agencies that might not have been receiving AIDS Office funding in the recent past). He added that one of the great disappointments of the awards process has been that an experienced agency lost funding. He said that he, like the Council members, values both experience and new blood. However, he saw no way to reconcile these two wishes, given the lack of an increase in overall funding for prevention. Again, he pointed out that it should not be surprising that all of those involved in this planning process feel a certain amount of dissatisfaction.

Dr. Katz commended the review panelists for their work; but he added that the reviewers, like the others in this process, have certain ways of seeing and certain values that they hold. Finally, Mitch Katz expressed his belief that the intentions of the AIDS Office were correct, and were to implement (as well as possible) the recommendations of the Council. He closed by saying that it is always easier to see the mistakes in retrospect.

Cynthia said that she had heard, in Steven's question, a concern around how the RFP had or hadn't met the guidance in the Plan. She noted that Mitch Katz seemed to be saying that the RFP **couldn't** have met the guidance in the Plan.

Steven spoke again to say that he was actually having the most trouble with Mitch's point about balancing provider experience with the need for new blood. He explained that he would have weighted the scale slightly more in the direction of experience, and that he believed the Council would not have wanted to leave the clients who were being served by the old contracts "hanging in the wind." He said that, if this priority for experience and a continuity of services to clients had not been clear enough in the Plan, then perhaps it should have been more heavily underscored.

Maria spoke up to address the discrepancies between the Plan and the RFP. She said that, in the end, it's a matter of accountability; people can have regrets and recognize their mistakes, but they

also have to be accountable for what they have done. She explained that, while the theory behind the Plan is based on behaviors, the Council also tried to put a special emphasis on the co-factors. She expressed her sense that, in the end, the awards represented an almost exclusive focus on behaviors, with very little attention to the influence of co-factors. She listed the specific areas in which she had the most questions about the decision-making process of the AIDS Office:

- the idea to limit the first RFP (#015) to behavioral risk populations (BRPs) 1-7, leaving out all non-IDU women (which Maria said was not a Council decision and did not reflect the spirit of the Plan);
- the creation of new service gaps, with the awards decisions on venue-based individual outreach (which Maria said seemed to reflect a reverse, rather than a forward, direction);
- the location of the gaps (which Maria said left her asking -- as a woman, an immigrant, and a person of color -- "Why is it always the same people" who are left as gaps and who have to fight to get anything?); and
- the tension in the Plan between experience and new blood (which Maria said did not account for the awards decisions around outreach, since the HPPC guidance did clearly specify that two years of agency experience providing outreach services for the particular population would be expected).

Mitch Katz responded that his goal for this meeting would be for people to see that the AIDS Office did its best to interpret the Council's recommendations, and did not plot to oppose the Council's wishes. He said that he did not expect people to think that everything the AIDS Office did was right.

As facilitator, Cynthia observed that people seemed to want to know what the process was for the decisions made around (1) the inclusion of BRPs 1-7 (and not 8-12) in RFP #015, and (2) the expertise vs. new blood to be represented in the prevention contracts for 1997.

In response to the questions about the inclusion of BRPs in RFP #015, Mitch said that it had been his understanding that everyone could apply for funding under the first RFP, but that proposals for populations beyond BRPs 1-7 would have to undergo a screening to determine whether their populations reached the minimum risk score of 100 points. Mitch added that, of the three proposals for populations below BRPs 1-7, two made it over the minimum score of 100 on review, based on co-factors. He explained that the AIDS Office had wanted to focus the most funding on the highest-risk groups, which the AIDS Office took to be those that the Council had ranked highest among the twelve BRPs. He said that the AIDS Office would not have made this choice again, and that he understood that it was a mistake. Mitch Katz pointed out that the AIDS Office is accustomed to convening review panels on smaller units, and that it is harder to get reviewers whose expertise stretches across modalities (to accommodate the new paradigm for prevention services). He explained that the AIDS Office had wanted to come up with some method for determining high enough risk (for review of proposals, and for prioritization of populations for funding).

Ana Claire offered a clarification that the risk scores for target populations were to be raised, not through co-factors, but through the application of the Matrix formula and the provision of more population-specific figures for behavioral risk (e.g., figures showing higher behavioral frequency). Ana Claire added that the Council had established this process for determining the scores for

particular target populations, and that the AIDS Office had picked the minimum score for proposal consideration.

Joshua spoke to say that the whole planning year had been rife with confusion and poor communication. Regarding the relative priority of experience vs. new blood, he said that the process didn't work out as expected and wasn't clear enough. Regarding the factor of ethnicity in organizing services, he said that the process had been difficult, because -- while he supports the use of BRPs for prioritization -- BRPs are not suited for use in the development and implementation of actual interventions. He explained that interventions have to be more specific, and have to be targeted to be culturally appropriate. He said that he didn't know why that wasn't taken into consideration, when the AIDS Office was supposed to be looking at the potential gaps in services. Joshua returned to his larger question: "What are we going to do about this now?". Cynthia asked him in whose area he saw the gap, primarily. Joshua responded that he didn't see it in the Plan, and that he felt the gap had occurred somewhere between the Plan and its implementation.

Mitch Katz said that he had thought that -- if you made a grid organizing populations by gender, neighborhood, ethnicity, and behavior -- you would not see a gap in services as they had just been funded. He explained that you could put a checkmark by each population in this type of grid, because each is covered with some prevention services. He explained that the problem arose around whether or not the Council viewed certain awarded agencies as culturally competent to serve the populations they were funded to serve. He said that people have very different views about whether a specific agency is competent in a specific area. Dr. Katz stated that, in order to achieve the Council's goal of covering all groups not just with services, but with culturally competent services, some consensus would have to be reached on what cultural competence is and how it can be measured.

Ana Claire asked where the AIDS Office was, in terms of trying to re-build trust, look at what services San Francisco has, and come up with solutions. Mitch Katz responded that this question, of where to go from here, is an important one. He said that he viewed this special meeting as a first step; and he noted that the HPPC and AIDS Office would need to make a joint decision about how to move forward. He pointed to miscommunication as having been responsible for much of what went wrong in the recent months of the planning process. He said that, on a contractual basis, the question of whether to see the current awards as shorter-term (instead of three-year contracts) would be a very difficult and mixed one for the Council. He identified this question as one that would require a separate discussion between the AIDS Office and the HPPC. He explained that the AIDS Office has, in the past, formed mostly one-year contracts, in order to meet the needs of a rapidly changing epidemic. He said that -- while he would not recommend re-doing the entire resource allocation process -- he would suggest looking at the new array of San Francisco prevention services, deciding as a Council how it should change, and then deciding on the steps necessary for changing it.

Ana Claire then asked a question that she introduced as being on a more philosophical level. Allowing for the sake of argument that the mistakes in implementation followed from a misunderstanding of the Council's recommendations, rather than from a willful misinterpretation, she asked whether the Council functions as an advisory body or more of a decision-making body. Mitch Katz replied that the Council is clearly a planning body. As an example of the HPPC's planning power, he reminded the group that the AIDS Office had implemented the HPPC's decision to organize prevention services according to BRPs (the decision that members often refer to as the "paradigm shift" that has taken place through the planning process -- focusing on risk for

transmission based on "what you do, not who you are"). Mitch Katz added that the AIDS Office decision to place **all** prevention funds under the jurisdiction of the HPPC, when it could have allocated General and State funds at its own discretion, stands as further evidence of the respect and loyalty granted to the HPPC as a planning body. (**Note from Ana Claire:** State funds do fall under the purview of the HPPC.) He explained that, while he sees the HPPC as a planning body, he does not see the HPPC as making decisions on dollar amounts. He suggested that the HPPC members might have to work together longer in order to make decisions more in the manner of the Mayor's Health Services Planning Council (also known as the Ryan White CARE Council), which sets the definite dollar amounts to be spent on services for particular groups (but does not allocate on a contract-by-contract basis). He added that he thinks it is harder to make some of these decisions in **prevention** (as opposed to health services) planning.

Cynthia summarized that Dr. Katz seemed to be saying that the AIDS Office sees the HPPC as a body that provides planning recommendations that the AIDS Office takes very seriously. She added that Dr. Katz had noted, as evidence of his deference to the HPPC's role as a planning body, that he didn't always agree with what was implemented. She pointed out that Dr. Katz had not, however, clarified whether the AIDS Office **could** refuse to implement the recommendations of the HPPC. Mitch Katz responded that there is no question that the HPPC guidance and Plan has to be implemented by the AIDS Office. He reiterated that the problem with implementing the Plan is that it's not always straightforward. Cynthia summarized/paraphrased that it is the job of the AIDS Office to interpret the Plan and then implement it, according to that interpretation. She explained that she was attempting to clarify where each body's power ends and the other's power begins. Mitch Katz answered that he has every incentive to interpret the Plan accurately, and that that is the whole point.

Bethsaida asked what would be the procedure for making changes to the Plan, should the AIDS Office disagree with any part of it. Mitch Katz replied that, in his understanding, the AIDS Office never made this kind of decision or move against following through on something in the Plan. Bethsaida explained that she was thinking of the HPPC decision not to set aside any funding for venue-based individual outreach services, and the subsequent production of RFP #016, in which the AIDS Office did specifically request proposals for venue-based individual outreach services, as a separate intervention category. Dr. Katz responded that, in his view, the issue of set-asides was not an issue directly related to the Plan. He explained set-asides as an issue for contracting -- for the implementation of the Plan. He stressed that he didn't feel that the set-asides were part of the Plan itself, but he noted that there was a tremendous amount of miscommunication around the question of the set-asides. Bethsaida followed these comments with a question about whether there might be other such cases (in which something given a discussion and a vote by the HPPC would actually have the status of an implementation issue, rather than a Plan-related issue; but might not be entirely obvious to the Council in its separate, implementation-oriented status). Dr. Katz said that he thought this issue would require a broader discussion. He noted that improvements had been made to the second RFP, which, for example, was open to an early review by people without conflicts of interest. He said that some issues, such as the assignment of points to proposals, might initially fall into a grey area, and might be able to be clarified in the Roles and Responsibilities document.

Cynthia pointed out to Mitch Katz that the input solicited and received by the AIDS Office from the committee and Council seems to have been understood by the Council as planning decision-making -- whereas Dr. Katz viewed it differently. Liz commented to say that she was glad that Bethsaida had mentioned the issue of set-asides, because it also relates to the discussion of the

priority of agency experience vs. new blood, in that everyone should go through the same process. Regarding the review process, she said that nearly everyone can be found to have some sort of conflict of interest. Her point was that, in the effort to screen out all potential conflicts of interest, the AIDS Office lost the actual community contact.

Chata addressed Dr. Katz directly, saying that he wanted to reassure him and the AIDS Office as a whole that the Council does not believe that the AIDS Office staff sat behind closed doors and intentionally opposed the HPPC. He said that the Council would like to be able to support the awards decisions and to understand the difficulties of the AIDS Office; however, he had trouble supporting the awards decisions because he didn't understand the reason for what appear to be numerous inconsistencies in the technical review reports. He added that he feels that the awards failed in the area of selecting culturally competent agencies, and that the outreach piece needs to be revisited and redone. Mitch Katz stated that he could not defend all of the comments or scores made by some of the community reviewers. He explained that part of the challenge for reviewers had to do with the sheer number of proposals to be reviewed at one time; and he added that the structuring of the RFPs to cut across modalities, genders, etc. meant that the AIDS Office had to exclude many potential reviewers on the basis of possible conflicts of interest. Finally, he said that the magnitude of the undertaking probably incurred a cost to the quality of the review. He stated that he would like to discuss with the Council ways in which the review process itself might be improved (for example, with stipends to ensure that reviewers thoroughly read the proposals they rate). He explained that he couldn't tell the community reviewers that their comments and decisions were not satisfactory. (At this point, a number of people present asked Dr. Katz why he couldn't critique and redirect the review in this way.) Dr. Katz said that the limitations of the review have to do with the problem of reaching consensus on priorities, and on the most important points to examine and count in proposals. He informed those present that the AIDS Office, historically, has tended to take a less directive approach to overseeing the review process. AIDS Office staff attend the review sessions to provide technical help, but do not vote and try not to let their own biases influence the proposal ratings. Dr. Katz suggested that the Council and AIDS Office might want to change this proposal review system together. In closing, he reiterated that it did not enhance the quality of the review to try to do so many different proposals all at once. Regarding the concerns around venue-based individual outreach, Dr. Katz told the group present that he had met with Pat Norman of ICHO and had spoken with former partners of the SOS collaboration. The Health Commission had heard the concerns of providers and the larger prevention community, and had asked the DPH to develop a plan to address them. Since then, the AIDS Office had asked the agencies that were previously members of the SOS collaboration, and that received funding in this round (e.g., TARC, HAFC, Proyecto Contra SIDA Por Vida, ICHO, and the Asian and Pacific Islander Wellness Center), to support their outreach workers. These agencies were requested to maintain their existing outreach staff, and New Leaf and Stop AIDS Project were asked (and agreed) to collaborate with one another to do outreach -- making use of New Leaf's experience with addressing mental health and substance abuse issues. For those agencies not receiving funding until July, the AIDS Office saved a one-time amount from 1997 contracts which have not yet begun (due to the delay in getting an agreement from the Health Commission), to maintain the other agencies' staff through June.

Chata said that Dr. Katz had only addressed the immediate needs arising from the funding cut to SOS. He explained that his question regards inconsistencies in the review process, which he sees as responsible for the awards made to East Bay agencies and agencies lacking in experience and/or cultural competence for serving their target populations. Chata asked Mitch Katz if he understands what members mean when they say that an agency is not culturally competent. He

noted that there was information on cultural competence in the Plan, and he expressed his sense that the review panels entirely failed to grasp this issue. In closing, he wondered aloud whether this lack of attention to cultural competence would serve as sufficient cause to re-bid the services.

Cynthia intervened to say that she believed Mitch had already responded to Chata's first question, about the AIDS Office's choice on whether to take reviewers' scorings or to go through a more subjective process. She summarized that the second piece of Chata's comment related to whether something new could happen from this point forward. Cynthia also gave the group a time check, noting that there were only 20 minutes of meeting time left. She asked the people still in line to comment to keep their comments brief -- from 30 seconds to one minute each, and she checked in with each person who was waiting to speak.

Ana Claire gave a two-part comment. Her first point was to ask whether the new contracts for venue-based individual outreach were even needed, considering the AIDS Office's plan to maintain the SOS outreach workers. Her second point was that -- as someone who participated on the Resource Allocation and Resource Inventory (RA/RI) Committee, in co-chair meetings, and in regular Council meetings -- she had understood the set-aside decisions as part of the Plan, rather than part of a separate realm of implementation. She said that the decision-making on set-asides was presented as a planning task that was within the purview of the Council, with the exception of the specific amounts to be reserved. She added that the decision on this item as a planning task was agreed upon by the co-chairs, Mitch Katz, and Jimmie Naritomi (chair of the RA/RI Committee) in a series of meetings. Mitch Katz responded that he was unsure about what had happened around the set-asides. He said that he knew he had felt disappointment when the Council did not support the RA/RI Committee's recommendations as a whole. His memory was that everything had changed at that point, but he was unclear on whether the decision was then deferred to the AIDS Office. Regarding Ana Claire's first point, Dr. Katz explained that the AIDS Office would not be maintaining the full SOS package. He said that he remembered people saying repeatedly that these services were needed, and that he had not worried about the possibility of having too much venue-based individual outreach. He added that, after agencies had been selected in what he considered a fair process, he did not want to revoke the awards given.

Joshua spoke briefly to say that this process (of this meeting) was not working for him. He said that, while he didn't have an answer to the problem, he felt that there was a "white elephant" in the room, and that everyone was dancing around it. He expressed sympathy for Dr. Katz' position, but reiterated that this discussion was not resolving the issues for him.

Barbara addressed the question of future directions that could be taken to prevent planning miscommunications and disappointments of the kind that the Council had experienced around the RFP and awards processes. She suggested that perhaps the Council and AIDS Office should have had many more meetings of this kind prior to this point in the process. She added that problems arise whenever one agency or individual is identified with everything that has gone wrong. She pointed out that there have been some gaps in communication between the committee and Council levels, so that committee members have found themselves surprised at the Council response to their recommendations. She also described a gap between what members think they are voting on and approving and what happens from there (implementation). Barbara stated that this meeting had worked for her in some ways; she appreciated hearing Dr. Katz speak about what he saw as having worked or not worked, about the time constraints and other limitations on the proposal review process, and about the task of interpreting the Plan. However, she said that she thought the Council, had it been consulted, could have given clear guidance on the interpretation of the Plan.

She supported the idea of a review process that would be brought back from the AIDS Office to the Council, as a way of preventing the development of such large communication gaps in the future. She stressed the need for greater connection between the AIDS Office and the HPPC. She explained that, with the kinds of miscommunication that have characterized the recent planning effort, Council members hear community speakers at meetings and feel more commonality with these outside perspectives than they feel with their own process.

Cynthia reminded the group that this discussion would be continued at the next Council meeting (on January 23rd).

Jimmie's first point regarded the technical review conducted for all applications that passed the initial criteria for consideration. He said that he hoped the reviewers understood and were following some criteria. He emphasized that some portions of the Plan gave guidance for incremental changes in service provision, and that not all of the expectations described were supposed to take effect immediately. Then Jimmie expressed his hope that the contracts that were initially planned to begin on January 1st would actually begin on March 1st. He said that he hoped that AIDS Office would not have to go through a whole new budgeting process to account for the delay in contract start-ups. Mitch Katz replied that the contracted agencies would be allowed to bill the AIDS Office starting on January 1st, but that the contracts would have to be certified later. He added that all work billed for these new contracts must fit the new unit of service definitions (based on strategies and interventions, as defined in the Plan).

Maria spoke briefly about cultural competency. She said that people were talking almost as if it were something that didn't exist. She stated that, if a provider does not share language, cultural roots, ethnicity, and class with the target population, then that service cannot be considered culturally competent. Cynthia recommended that Maria bring this definition to the Council for discussion. Maria then turned to the issue of future directions; she said that the Council had some concerns and felt the need for some negotiation.

Vic apologized for having arrived late. He supported Barbara's and Joshua's comments about communication. He added that he was hearing people bring up questions that were answered in the Process Evaluation Team's newest "Chron. Log" document. He said that he felt the Council and the AIDS Office needed to get moving and take some action. For better communication, he suggested that everyone devote more attention to reading the Council materials, listening to the discussions, and using all of their senses to absorb what goes on. Regarding cultural competence, he proposed that the Council go ahead with the development of specific guidelines. However, he pointed out that cultural competence could not be the only factor considered in the review of proposals. He explained that a number of people on the review panel, himself included, spent a lot of time on the issue of cultural competence, and that it would have assisted them to have had guidelines. He said that the records and review procedures should be made public, and that people were making comments about some proposals that they hadn't even seen. He asked the Council to try to remove itself from the circulation of rumors and innuendos. Finally, he suggested that people speak in more specific terms in their comments, cutting to the chase in order to move forward.

Ana Claire stated that all of the preceding discussion had underscored the importance of having Dr. Katz be involved in the future Council and Roles and Responsibilities discussions, in order to avoid in the future the kind of confusion that the Council had experienced in past months.

Speaking about the outcome of this meeting, Cynthia said that it seemed to her that the information that had needed to be exchanged between the HPPC and Dr. Katz had been exchanged. However, she noted that there was insufficient room for discussion, and that other issues could not be put on the table. She suggested that a certain lack of dynamic might be embedded in this process, and that other settings for discussion might be more fruitful.

Mitch closed with an announcement and a suggestion. He thanked Valerie for serving so ably as the DPH co-chair of the Council (from 1994-96). He said that, in addition to Valerie continuing to serve the Council as an AIDS Office staffmember, he would like to see Gene Copello serve as the DPH co-chair (and had asked him to do so). He explained that Gene's supervision of all three units of the Prevention and Health Programs and Policy Branch of the AIDS Office should ensure that the broader functions of the planning process, the RFPs, the contracts process, and the monitoring happen smoothly and in coordination with one another. He noted that Valerie would act as DPH co-chair at the next HPPC meeting, to make the transition to the new Council. Dr. Katz' suggestion for the longer-term functioning of the Council was that the members might want to examine their own by-laws. He said that there is some question as to whether this Council is really "gelling" as a group, and he pointed to the issue of membership rotation and the sheer amount of committee work -- which can serve as a barrier for continued full Council participation. He posed a question to the Council, about whether it would want to have its members spend less time in committee and more time in the larger group.

As the group broke up, announcements were quickly made about the Orientation to 1997 meeting (to take place on the following afternoon), the continuation of this discussion at the January 23rd meeting, and the completion of evaluation forms on this discussion.

Enclosed with These Minutes (for those absent):

- Process evaluation document: "HPPC Year 3 Actions Regarding RFP"
- Process evaluation document: "Summary of Key Decisions in Year 3 RFP Process"
- Process evaluation document: "HPPC Survey: Preparation for Meeting with Mitch Katz -- Results"

Next Meeting: Thursday, January 23, from 3-6pm at the First Unitarian Church -- 1187 Franklin

Minutes Recorded by: Mary Irvine
Minutes Approved by: Outgoing DPH Co-Chair Valerie Kegebein, Director of the AIDS Office Mitch Katz, and Community Co-Chair Ana Claire Meyer

HIV PREVENTION PLANNING COUNCIL

January 16, 1997

The Agenda of this meeting is missing.

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HIV PREVENTION PLANNING COUNCIL ORIENTATION
ABBREVIATED[1] MINUTES
January 16, 1997

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Members Present:
Ronnie Ashley (Chata)
Isabel Auerbach
Christine Edwards
Roberto Garcia
Ellen Goldstein
Natalie Gutierrez
Vic Hernandez
Liz Highleyman
Jelousy Jiggetts
Valerie Kegebein
Sacul L'Adnbre
Ana Claire Meyer
Askia Muhammad
John Newmeyer
Henry Ocampo
J. Colin Partridge
Dawn Passar
Mark Peppler
Joel Reyna
Maria Rinaldi
Bethsaida Ruiz
Steven Sams
Joshua Volle
Gregory Walker

Members Absent:
Barbara Adler
Ahimsa Timoteo Bodhran
Hector Carrillo
Gene Copello
Patrick Forte
Jennifer Lorvick
Jimmie Naritomi
Terry Ryan
Sandy Simms
Irma Torres

AIDS Office Staff:
Brian Dobrow

Polaris, Inc./Harder + Co.:
Ellen Irie, Harder + Co.
Mary Irvine, Polaris
Steven LaFrance, Harder + Co.
Lyn Paleo, Harder + Co.
Oscar Trujillo, Harder + Co.

Process Evaluation Team:
Kathleen Roe
Kevin Roe

Guests:
Nick Farrell, CDC (Project Officer for the City of S. F.)
Cynthia Gomez, CAPS (co-facilitator for this meeting, and former Council co-chair)
Ann Ueda, LIFE Institute (a consultant to the Roles and Responsibilities Task Force)
Stacy Vogan, HIV/STD Prevention Training Center

1. WELCOME & ANNOUNCEMENTS *Ana Claire Meyer and Ronnie Ashley (Chata)*
Community Co-Chairs Ana Claire and Chata convened the meeting shortly after 2:00pm, and began the round of introductions.

Kathleen Roe briefly explained the HPPC process evaluation handouts that were distributed at this meeting: the results of the participant dialogue boxes from the special meeting with Dr. Mitch Katz (enclosed for those absent), and the evaluation and participant dialogue forms to be filled out for this orientation. In response to a question from Steven Sams, she informed the Council that members may fax in their meeting evaluation and participant dialogue forms after the meeting, but

[1] Because this meeting was not a regular business meeting of the Council, but was instead scheduled to help members prepare for their prevention planning work in 1997, this is simply an outline of what took place. Regular business meetings are a matter of public record, and are written up in greater detail.

that the faxed forms may not make it into the first summary of results for that meeting (since the evaluators turn these results around within a day or so). Responses faxed too late to be combined with the other evaluation results may be shown as an addendum to the first set of results. Kathleen Roe also let members know that they may write a note in the participant dialogue boxes for an individual, and request that it not be published broadly with the other feedback. This note can be conveyed to the individual by the evaluators, allowing the person writing it to maintain anonymity.

2. ¿QUIENES SOMOS? *Joshua Volle*

Joshua Volle led the group through this exercise, after sharing some definitions of culture (using quotes from Noel Day, from Chris Sandoval, and from Chata). All present wrote down a series of pertinent facts about themselves and personal messages, logos, etc. on pieces of butcher paper, which were taped around the room for others to read/view. The exercise allowed planning participants to find out about some of the diversity of backgrounds, interests, and perspectives represented in the planning process. Afterward, participants were invited to sit in the circle again and ask each other questions about their individual '¿Quienes Somos?' pages.

3. WHAT IS PLANNING? *Ellen Goldstein and Cynthia Gomez*

Ellen Goldstein led everyone present through a brainstorming exercise on the differences between community planning and a non-community or a non-planned approach to HIV prevention decision-making. Then Ellen Goldstein and Cynthia Gomez asked each person to make a list of their five top priority populations for prevention services, and -- on a separate piece of paper -- to write their reasons for choosing those five populations. Cynthia read the explanations aloud, while Ellen compiled a list of all the priority populations selected by the group. Those present noted some patterns in the reasoning behind selections: **(1)** use of epidemiological data (especially prevalence), **(2)** use of experience with clients, **(3)** a focus on risk behaviors, **(4)** an intent to reach those who have not yet been reached with prevention, and **(5)** reference to the Plan. Despite these similarities in members' approaches to the problem of prioritization, a large number of different populations were actually selected as the top priorities. As Ellen and Cynthia pointed out, while people tended to agree on the methods for prioritization, they came up with varied results. Ellen noted that almost everyone had put youth somewhere on their list. This exercise led into a discussion of some of the differences and connections between the earlier years of S. F. community prevention planning and the third and fourth -year Councils. Cynthia described the shift of the planning effort from the development stage to the stage of implementation, evaluation, technical assistance, quality assurance/monitoring, and information-sharing. She also offered her continued availability and support for this process. She said that she would be happy to talk to current members, and that she answers her own phone line at CAPS. In closing, she wished the 1997 Council the best of luck.

-- BREAK --

4. MEMBER RESPONSIBILITIES *Ellen Goldstein*

Ellen led members in this brainstorming exercise, in which people identified the following roles, responsibilities, and purposes of Council members in participating in the planning process:

- to be prepared and keep up -- it's a lot of work;
- to be on time;
- to be aware of language difficulties and differences on the Council -- use verbal as well as written communication;
- to serve on committees -- where there is an enormous amount of work to be done, and an enormous amount of experience to be gained;

- to get information back to the communities that members represent;
- to fulfill an obligation to employers (some were told that they had to serve on the Council);
- to read the materials, try to understand the materials, and prepare for critical votes -- keeping in mind the purpose of advocating for and serving the people of S. F.;
- to make sure that the information and research developed for prevention is made accessible and useful to the communities affected (bridging the gap between research and service provision); and
- to speak up -- say what you want to say, never fearing that it will sound stupid.

On pieces of paper cut out into hat shapes, the people present then wrote the different jobs, interests, roles, experiences, etc. that they bring to the planning table; and they pinned the hats on their bodies. People read each other's hats, and talked about their own.

5. ORIENTATION TO THE PLAYERS *Ana Claire Meyer*
Using a handout (enclosed for those absent), a map created by Harder + Co. staff, and cards bearing the names of different players in the field (national, state, and local) of HIV prevention -- members located the core HIV prevention players and described their individual roles.

6. SELF-CARE/CARING FOR OTHERS *Chata and Natalie Gutierrez*
Ellen seguewayed into this exercise by mentioning the potential for this community planning process to become stressful at times, and the need for members to remember (a) why they're involved, and (b) how to care for themselves and others.

A long red ribbon was passed around the circle and held by all present. People were invited to write the names of colleagues, friends, and loved ones lost to AIDS or infected with HIV, and to write any messages or thoughts to/about these people. Natalie Gutierrez and Chata shared their strategies for self-care and for surviving with compassion in this pandemic. Others who wished to do so spoke, and shared their feelings and methods of caring for themselves and others.

7. PROCESS EVALUATION *Kathleen Roe*
Participants were asked to write, before leaving, where their hearts were at this moment. The slips of paper were collected by the process evaluators.

8. CLOSURE *Valerie Kegebein*
Valerie closed the meeting with a personal statement.

Enclosed with These Minutes (for absent Council members):
- Participant Dialogue boxes with the results from the 1/15/97 HPPC meeting with Dr. Katz
- "HPPC Orientation for 1997 -- List of 'Players'"
- Organizational chart for the Prevention and Health Programs and Policy Branch, and the Prevention Planning, Policy and Health Education Section of the AIDS Office
- Updated Membership List for 1997 (as of 1/16/97)

Next HPPC Meeting:
♦ Thursday, February 13th, from 3-6pm at the First Unitarian Church -- 1187 Franklin St.

Minutes Recorded by: Mary Irvine
Minutes Approved by: Outgoing DPH Co-Chair Valerie Kegebein and Community Co-Chair Ana Claire Meyer

Revised 1/23/97

HIV PREVENTION PLANNING COUNCIL MEETING

January 23, 1997
3:00 PM 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Valerie Kegebein
Ana Claire Meyer
Ronnie Ashley (Chata)

Please read: **Agenda and minutes of December 12**
***Please bring*:** **Entire Package**

Agenda

1. Welcome & Introductions	Valerie Kegebein	3:00 - 3:05 PM
2. Minutes from December 12	Valerie Kegebein	3:05 - 3:10 PM
3. Announcements	Valerie Kegebein	3:10 - 3:15 PM
4. Public Comment	Valerie Kegebein	3:15 - 3:35 PM
5. Process Evaluation Report	Kathleen Roe	3:35 - 4:20 PM
6. Break		4:20 - 4:30 PM
7. Roles & Responsibilities Discussion	Ana Claire Meyer	4:30 - 5:00 PM
8. Follow Up to Meeting with Director of AIDS Office	Valerie Kegebein/Chata	5:00 - 5:45 PM
9. Closure for 1996 HPPC	Co-Chairs	5:45 - 6:00 PM
10. Meeting Evaluation	Valerie Kegebein	6:00 - 6:05 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC - February 13, 1997, 3-6 PM, First Unitarian Church, 1187 Franklin Street (@ Geary).

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HIV PREVENTION PLANNING COUNCIL
MINUTES
January 23, 1997

Members Present:
Barbara Adler
Ronnie Ashley
Isabel Auerbach
Ahimsa Timoteo Bodhran
Hector Carrillo
Gene Copello
Roberto Garcia
Ellen Goldstein
Liz Highleyman
Valerie Kegebein
Sacul L'Adnbre
Ana Claire Meyer
Askia Muhammad
Jimmie Naritomi
John Newmeyer
Henry Ocampo
J. Colin Partridge
Dawn Passar
Mark Peppler
Maria Rinaldi
Bethsaida Ruiz
Steven Sams
Joshua Volle

Guests:
Luis Barahona, MARCC
Dredge Kang, CAPS
Cynthia Laird, BAR
Clark Taylor, SFCC
Joanne Tornatore-Pili, MARCC

Members Absent:
Christine Edwards
Patrick Forte
Natalie Gutierrez
Vic Hernandez
Jelousy Jiggetts
Jennifer Lorvick
Joel Reyna
Terry Ryan
Sandy Simms
Irma Torres[1]
Gregory Walker

AIDS Office Staff:
Brian Dobrow
Marcy Fraser
Delia Garcia
Mike Pendo

Polaris, Inc./Harder + Co.:
Mary Irvine
Lyn Paleo

Evaluation Team:
Pali Basi
Ruel Caneda
Cathleen Farrell
Kathleen Roe
Kevin Roe

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1. WELCOME & INTRODUCTIONS

The co-chairs began the meeting with an exercise. Each person sitting in the HPPC circle was asked to talk to the person on their right and find out something about that person that nobody else knows. Then everybody introduced the person next to them, by giving that person's name and disclosing the new fact about them.

2. MINUTES FROM DECEMBER 12

Regarding the minutes of the last full Council meeting, the following corrections were made:

[1] Irma Torres, whose name appears on the most recent membership list, was actually unable to be appointed to the Council.

- The final motion for the vote on HPPC letters of support for prevention intervention proposals was made by Hector Carrillo and seconded by Liz Highleyman. (It was not called by Joel Reyna, as the minutes state, although Joel contributed to the content of the motion.) *This change was submitted at the meeting on January 23rd.*

- The first sentence under "WELCOME & INTRODUCTIONS" should have reflected the fact that some Council members do not have agency affiliations. Not everyone is expected to announce an agency along with their name, in the introductions that begin each meeting. *This change was submitted at the January 15th meeting with Mitch Katz.*

- The agency affiliation shown next to Tony Molina's name on the guest list should read "LCA/S," not "LCAIS." The organization's full name is the Latino Coalition on AIDS/ SIDA. *This change was submitted to Polaris, Inc. over the phone on January 15th.*

- Tony Molina, who clarified that he was speaking for himself during public comment, and not for any agency or planning group, did not simply state that "...he had sex in the parks," as the minutes paraphrase. He specifically and intentionally used the language, "I fuck in the parks," and he wanted his choice of words to be reflected in the minutes. *This change was submitted to Polaris, Inc. over the phone on January 15th.*

3. ANNOUNCEMENTS

Co-Chairs Ana Claire and Valerie:

- At the Health Commission meeting on Tuesday, January 21st, the prevention contracts were on the agenda again, and they were all approved by the Commission -- with one abstention and one opposing vote. The prevention contracts are now official. Health Commission minutes are also available to the public (enclosed for all Council members).

  Discussion

  In response to a question from Ellen, Ana Claire and Valerie explained that the AIDS Office response to the Health Commission's concerns was delivered in a verbal report, which is summarized in the Health Commission minutes. Regarding the response of the CDC to the HPPC Letter of Concurrence (with concerns) attached to the CDC Application, Valerie stated that the CDC had noted the concerns and had suggested the CDC provision of technical assistance to the HPPC process. Nick Farrell has been serving as the CDC representative providing TA, and he will give a report back to the CDC and to the AIDS Office, which will share the information with the HPPC.

  Ellen also asked whether the section of the Health Commission minutes relating to the AIDS Office verbal report could be copied to the Council, along with the technical report from the proposal review process. Valerie replied that the Commission minutes could be sent to Council members, but that the technical report was much more lengthy. In order to conserve staff time, paper, and postage, the technical report will be kept at the AIDS Office and copied to members on request.

Roberto Garcia:

- Shanti is putting on a benefit dance party for its Latino program. The party will take place at Cesar's Latin Palace on Friday, February 14th, from 8pm-midnight. (See the flyer, which is enclosed for all members.)

Lyn Paleo:

- One of the front-page stories of the 1/23/97 Bay Area Reporter discusses the new Plan: "HIV Prevention Plan Lands With a Thud." Lyn recommended that people read this article (enclosed for all members).

Discussion

Valerie noted that the DPH expects to issue a press release on the Plan, and has also been asked to give a presentation on the Plan at the Health Commission. She added that copies of the Plan would be made available to HIV prevention providers as of 1/24/97, and would be available for pick-up at the AIDS Office. She said that, if there was any response that the Council would like to make to the press on the Plan, she would encourage discussing it.

Isabel asked Lyn if she could summarize the BAR article for the Council. Lyn briefly obliged, stating that the headline refers to the Plan's length of 700 pages, and to the lack of a chapter on condoms. She pointed out that the article had misstated that the new sections of the Plan were the Strategies and Interventions Chapter and the Priority Setting Chapter (while these sections were in fact developed in 1995, and the other sections are all either new or significantly revised). Lyn added that the article includes quotes from Gene Copello and Valerie Kegebein, explaining why the Plan does not have a separate condom chapter and explaining the HPPC's focus on behavioral risk groups.

Jimmie asked for the information on why there was no condom chapter in the Plan, and Valerie and Gene recapitulated their quotes from the article (enclosed for all members). Jimmie also suggested that the article be copied to the Council, if Council feedback was desired. Valerie agreed, and suggested that the HPPC could write a letter to the editor. She added that condoms are just one issue for HIV prevention, and that they are discussed in the Strategies and Interventions Chapter. There is no chapter in the Plan devoted to any single prevention tool; each chapter covers a lot of information.

Lyn asked whether the Council would like to empower the co-chairs to write a letter to the editor. Gene noted that there were also other articles in the BAR dealing with the RFP process and the Plan. Ellen said that it was nice to have Cynthia Laird present at Council meetings, since the Council members want the community to know what they are doing, and the press is an important way of getting the information out there. Valerie closed the discussion with a suggestion that people on the HPPC read the article on the Plan and contact the co-chairs, if they want to participate in formulating a response.

4. PUBLIC COMMENT

- *Joanne Tornatore-Pili of the Multicultural AIDS Resource Center of California (MARCC)* introduced a packet of materials that she had copied and brought to the meeting for Council members. She explained that the packets included information from some recent focus groups that MARCC/Polaris staff had conducted, as well as flyers describing the MARCC's technical assistance and training services, which are available at no cost to all State Office of AIDS-funded prevention providers in California. Joanne also congratulated the Council on its completion of the Plan.

- *Clark Taylor of San Francisco City College (SFCC)* remarked that the Plan looks pretty good, although it lacks information on sexual theories of behavior change. Clark expressed his concerns that, while his first letter to the AIDS Office was distributed to Council members (on 12/12/96 and in the minutes for that meeting), the second one was not distributed, because of a requirement that documents to be sent to the HPPC be introduced with an announcement at an HPPC meeting prior to the mailing. Clark complained that this requirement of in-person presentations at the Council had prevented the timely release of newer information to the membership. He said that, at this point, it was too late for the Council to do anything about the SFCC proposal review and appeal rejection (and there had been no official HPPC business meeting scheduled for the time between December 12 and January 23). Clark suggested that, in the future, it would help to have a way to fit time-sensitive mailings in with other mailings to the Council. He added that SFCC would have been happy to provide the postage for a mailing of its second letter, since its priority was simply to get the letter out to members.

  HPPC Response to Public Comment
  Ana Claire explained that the budget for the administration of the planning process does not allow for unlimited copying and postage, and that the requirement of announcements for attachments to the minutes had arisen as a method of preventing people from churning endless pages of material through the Council. Valerie added that some people have not wanted their home addresses and phone numbers (which appear on the membership list) to be publicized outside of the immediate Council and its consulting staff. She said that the co-chairs could determine which members are willing to have their mailing addresses and phone numbers released, and could then make the resulting list public for future use. Then anyone wishing to send out a special mailing to the Council, without attending a meeting to make an announcement, could use the list and handle the copying and postage individually.

5. PROCESS EVALUATION REPORT

Kathleen Roe introduced her presentation by explaining the role of the HPPC Process Evaluation Team, which constantly collects, summarizes and presents information from the planning participants, so that the process can be informed by the perspectives and experiences of those involved. The Process Evaluation Team keeps an ongoing record of the planning decisions and of the participants' feelings about those decisions and their own dynamics, and produces a feedback loop enabling the larger Council to respond to its members' observations, concerns and expectations. Kathleen noted that the evaluators occasionally lapse into using the term "we" when talking about the Council, because they become absorbed in working with the process, and can sometimes forget that they are not actually part of the Council. She clarified that the evaluators are not on the Council, but that they have asked to be able to have a representative sitting at the table with the members, and they have been granted this request by the Council.

Kathleen Roe identified herself as a professor of Community Health at San Jose State University, Department of Health Sciences. She teaches as a working professor, in addition to doing her consultant work outside of the university. She talked briefly about the way in which academics can get a bad name, along with bureaucrats, and she explained that -- while she understands the reasons for this -- she is proud of her academic work and believes that both academics and bureaucrats can use their positions to bring change and progress. She described her own enthusiasm for working with her students (all of whom are studying community health education, and most of whom are doing graduate work), and she said that they come to this process cheaply

and with a lot of energy. Kathleen Roe mentioned her good fortune at having this opportunity to work with her brother, Kevin Roe, who also has a degree in health education.

Kathleen Roe then informed the group present that she was going to speak about this group in a familiar and personal manner, and that she would ask the press and others from outside of the Council to treat this information with respect and some confidentiality. In order to honor this request, these minutes will not discuss the details of the presentation that followed. However, Kathleen Roe has agreed that the overheads which she used should be shared with those Council members who were absent. In her address at this meeting, she characterized the Year Three planning process through the use of particular icons and analogies, discussed what the Process Evaluation Team data suggested about the Council (the greatest and the least -developed areas of members' experience), and touched on other themes in the process (which the Council was unable to resolve in the course of this year).

In closing, Kathleen Roe told the Council that it could use the Process Evaluation Team in whatever ways it finds helpful. She explained that, this year, the Evaluation Team had waited for an invitation from the Council to give more extensive and specific kinds of support (since the AIDS Office, not the HPPC, hired the evaluators -- and she did not want the evaluation activities to become intrusive). For the coming year, she suggested that the Council members might want to be working with the Process Evaluation Team members all along, and taking whatever they need from the evaluators in both small-group and large-group settings.

Discussion

Chata said that what he found amazing about the Year Three process was how much the Council didn't know at the beginning but had learned by the end. He said that the members had all had patience, anger, passion, and courage -- but had found the planning process to be difficult and new. Ellen pointed out that there had been a great deal of adrenalin involved in the third-year process, and that this was a hard place from which to work. She expressed her sense that it would improve the work of the Council to be able to lower the adrenalin levels in the process this year. Dr. Roe agreed that it is difficult to produce a centered and grounded response to an adrenalin-driven process. Sacul mentioned her appreciation of the exercise (led by Ellen and Joshua at the 1996 retreat) that measured participants' strengths and energy levels. She added that she thought the members had talked about incorporating this kind of exercise into the regular meeting process, but that it had never happened (others present murmured a confirmation of this unrealized intent). Sacul also said that she hadn't felt right about the HPPC end-of-year party and gift exchange; she explained that many of the members had been afraid that they wouldn't have a job this year, and that she hadn't even been sure that she could afford to buy gifts for her own friends and family. She said that this incongruity around the gift exchange wasn't funny, and that a lot of people hadn't thought about how it would feel. Kathleen Roe affirmed Sacul's point that the gift exchange/party was painful, and was made all the more pathetic by the awareness that it was supposed to be fun and wonderful. She said that more attention needed to be paid to the process and dynamics behind this powerful planning body, and that the Membership Committee should always be at the heart of the HPPC work.

Kathleen Roe then distributed the forms with results from the evaluation and participant dialogue boxes for the 12/12/96 HPPC meeting (enclosed for those absent).

6. BREAK

7. ROLES & RESPONSIBILITIES DISCUSSION

Ana Claire opened this discussion by informing the group that the co-chairs would try to take a **concept vote** at the end, and explaining the purpose of this procedure. The Council developed the concept vote in 1996, as a means of **(a)** informing the Council in advance of the substance of a motion that would eventually require a final vote, and **(b)** learning where Council members stand on an issue, in time to take the item back to the committee and consultants for any revisions needed prior to the final vote. As Ana Claire explained, a concept vote in favor of a motion would amount to an agreement with the direction that the body behind the motion (generally a committee) was taking. The Council agreed in 1996 that it would be valuable to have any reading materials relevant to a concept vote distributed to Council members prior to the meeting at which the vote would take place; this would ensure that members had had time to study the documents in question, and to formulate their responses. In this case, however, the draft document (generated by the Roles and Responsibilities Task Force, and enclosed for those absent) had only just been produced for Council consumption, and had to be distributed at this meeting.

Ana Claire apologized for the lack of time for members to read through the entire draft Roles and Responsibilities document, and briefly summarized that the first three pages refer to the recommended procedures for addressing Council members' concerns related or unrelated to committee work, while the last three pages focus on where the task force/committee is going with its work and what questions remain to be answered for the completion of this task. She explained that the task force/committee expects to come up with those other answers, to produce a new draft for discussion and voting in the Council, and to send the final draft along to Mitch Katz, Gene Copello, and Sandra Hernandez.

Ana Claire informed the larger group that the Roles and Responsibilities Task Force had had three meetings by this time, and that Mosi Mays-Mirembe from the LIFE Institute had facilitated the last two meetings. (Her technical assistance is provided by the State Office of AIDS in Sacramento.) This task force has also been receiving technical assistance from Ann Ueda of LIFE Institute (for the State of California). The last two meetings focused on the areas of **communication** and **conflict resolution**. Specific responsibilities have yet to be outlined under these two areas, as well as under **mutual accountability** and **grievance procedures**. The draft document offers some suggestions for what members can do, even if they only represent a minority opinion, when they have particular concerns about a set of recommendations. For example, if consensus cannot be reached, and a motion passes by a majority, but a strong minority opinion remains -- those (or the singular member) holding the minority opinion may write a letter of concern, to be incorporated into the minutes packet. One change suggested by the task force would allow members to ask for more time on the agenda for a discussion, when an issue cannot be resolved satisfactorily in the time originally allotted.

Question and Answer

Roberto asked for clarification on whether, if a minority of members still wanted to continue with a separate process, after all the procedural steps and the final vote had been taken, that minority could pursue the matter on its own (outside of the Council). Ana Claire responded in the affirmative, but stated that the members taking action outside of the Council could not claim to represent the Council as a whole. Ana Claire added that any member who would like to see a particular issue put on the Council agenda should ask the co-chairs and specifically request time on the agenda for that issue. According to the recommendations of the task force, the person (or people) bringing the issue to the Council would be expected to collect information, talk to others in

the community, and present the issue during the time reserved for it on the meeting agenda. The Council would then try to decide at that meeting whether to pursue the issue as a full Council.

Ana Claire noted that, at the next Roles and Responsibilities Task Force meeting, members would work on (1) creating a concise statement about mutual accountability, and (2) defining the roles and responsibilities of particular positions in the planning process (e.g., director of the AIDS Office, chief of the Prevention and Health Programs and Policy Branch, technical consultant, logistical consultant, etc.). She also informed the group that the Membership Committee would work on outlining grievance procedures. Lyn noted that the draft document shows all the areas on which the task force will be working, and she stated the motion for a concept vote to approve the general direction that the Roles and Responsibilities Task Force was taking.

Steven pointed out a problem for current concept votes, in that new members could not yet vote officially, but would be able to vote at the time of final decision-making on this document. He noted that a concept vote without input from new members would not serve the purpose of reflecting the full Council's view of the direction taken by the task force/committee. Ana Claire acknowledged Steven's point, and suggested that, for this transitional meeting, a **straw poll** (including every new and old member present) be taken **instead of a concept vote**. She stated that the discussion of this motion should also include every Council member in attendance, and Barbara added that the task force/committee would incorporate the input from the discussion, as well as considering the results of the straw poll. Jimmie noted that new members could refer to the Council by-laws, to answer any procedural questions that they might have; but he wanted members to understand that the by-laws are also subject to ongoing revisions.

Further Discussion of the Motion

Chata mentioned his pride in the work that had gone into the Roles and Responsibilities draft document. While he admitted that the document could still benefit from some "ironing out," he described it as **a foundation** for how the participants in this collaborative planning process will work together.

Sacul expressed her frustration at hearing statements, during the December meeting, which indicated that the Council lacked the **power to effect change**. She said that she had been carrying around a sense of futility, and wondering why the Council members were here, if not to change the system of prevention services. Ana Claire responded that the Roles and Responsibilities Task Force had been trying to figure out the bounds of the power held by the Council -- power "to do what?" and "over whom?". Sacul continued to ask why this was not a Council with the power to make change and to challenge the powers that be, on the issues with which the Council was dissatisfied. Valerie replied that all of the details of the Council power and purview have to be spelled out and defined, because this has not happened before now. She added that, once this definition has been accomplished, it may mean that some actions -- once they are taken -- cannot be changed by the Council, while others can. Ana Claire spoke up to **distinguish "power" from "authority."** She explained that the Council has power, but does not always have authority (over the funding of contracts, for example). Some decisions do not fall under the realm of what the Council has been charged to do in the planning process. She closed by saying that the current task was to figure out just what the Council can and cannot do. Kathleen Roe added that part of the goal of the Roles and Responsibilities Task Force is to extend the power, authority, and purview of the Council -- and to flesh it all out in writing, so that it will be there when members need it. She stressed that it is important for Council members to know the leverage that they have.

Jimmie said that he would like to add a fourth column to this discussion of roles and responsibilities. He pointed out that this is not just a question of what power or authority belongs to the Council, the AIDS Office, and the DPH -- but also of what issues might come under the **shared responsibility** of these groups. He articulated a need for mutual accountability and for clear lines of communication between these different planning parties. He added that Mitch Katz had implied, in the special meeting held on 1/15/97, that he would like to see the Council taking on more authority in certain areas.

Steven expressed his hope that the Council would be able to look at the RFP process itself, and to give input into that process. Valerie noted that this comment gave a perfect segueway into the invitation of Council members to participate in a **task force organized to improve future prevention RFP processes**, based on experiences with the 1996 RFP/proposal processes. She pointed out a stack of sign-up sheets (enclosed for those absent) in the center of the room. (Priority will be given first to the members of the former Resource Allocation and Resource Inventory Committee, and next to others who witnessed the unfolding of the RFP process in the 1996 HPPC.) Steven added that it would be helpful to be able to separate the roles of the AIDS Office and the DPH, with regard to the RFP process.

Liz commented that she wasn't sure why the HPPC, unlike the HSPC (the Mayor's Health Services Planning Council), did not have influence over the **levels of funding to go into particular service types**. Ana Claire responded that, in part, this different has to do with who convened each Council -- the CDC for the HPPC, and HRSA (under the Ryan White CARE Act) for the HSPC. The HPPC has the responsibility to set priorities for resource allocation, but the extent to which it is actually involved in the resource allocation is left open in the written guidance. Gene added that, while the HSPC is legally mandated to allocate funding to service categories, the CDC guidance for the prevention planning process leaves open the **option of resource allocation.**

Hector made the point that, within the discussions of planning process roles and responsibilities, the Council would eventually have to talk about **conflicts of interest** between planning functions, jobs, individuals, etc.

With this discussion concluded, Valerie initiated the straw poll on the direction being taken by the Roles and Responsibilities Task Force (as evidenced in the draft document distributed today).

Straw Poll

In Favor:	**15**
Opposed:	**0**
Abstentions:	**3**

Consensus was reached by the group of members present, in favor of the concept of the Roles and Responsibilities Task Force recommendations.

8. FOLLOW-UP TO MEETING WITH DIRECTOR OF AIDS OFFICE

For this agenda item, the co-chairs asked that members of the Roles and Responsibilities Task Force (who had already had opportunities to discuss the 1/15/97 meeting with Dr. Katz) withhold their comments until other members had spoken. Without further introduction, the discussion was opened up for old and new members' comments.

Discussion
Steven stated that he still didn't understand exactly what was included in the RFP **review process**, in terms of **criteria, ground rules or preparations**. He said that this lack of knowledge about the review left him uncomfortable and at a loss for how to stand up for the results.

Liz said that she had learned a great deal at the special meeting, including some things that she thought she **should have known all along**, as a member of the Council (e.g., Mitch Katz' philosophy of planning, and the difficulties arising from a sudden overhaul of the system of resource allocation).

Mark described the discussion of the tensions between an **"objective" and "subjective" review** process as interesting, and said that the issue deserved further clarification (i.e., should reviewers judge a proposal as related to the reputation of the applicant agency, or should they see it as totally independent?).

Maria told the group that, in reading the dialogue boxes from that meeting, she felt that she represented a minority opinion on the meeting's outcome. While others appeared to have found the meeting productive, she had not had that experience. She had expected to talk about the **communities who had been coming to address the Council in public comment, and the communities whom the prevention agencies must serve**, and not just about Mitch Katz' philosophy of planning. None of what she had wanted and expected from the meeting had been realized. She closed by saying that the Roles and Responsibilities Task Force has been left with a lot of issues to resolve, but that this resolution will have to serve for the future, and cannot remedy the current situation.

Barbara expressed her sense that it was unfortunate to have been told of **Valerie's departure** from the co-chair role only at the very end of the January 15, 1997 meeting with Mitch Katz -- so that there was no way for Council members to process it. She said that she assumed that Valerie would not stop working for the Council, and that she understood that Valerie had had a great deal projected by others onto her name and person. However, she still didn't feel right about the way in which the announcement was made to the Council.

Askia said that, as a new member, he had been surprised to hear that Dr. Katz felt locked into a procedure and a system beyond his control, and that he agreed with some of the concerns of Council members. Askia also testified that, as someone working with the community, he can anticipate what **the fallout** (of the RFP/awards processes) will be in the community. He said that the planning participants have to come to some consensus about the situation facing them.

Valerie stated that she felt it would be useful to put together a written **document on all of the steps that go into an RFP**; she offered to compile this document at the AIDS Office, for the Council.

Chata framed his questions to the Council as, **"Where do we go from here?"** and "What would that place look like?". Speaking personally, as an infected/affected community member, Chata said that he was unhappy with the meeting. He felt that many of the Council's questions had gone unanswered, and that there appeared to be a lack of room for movement or for change in this process. He noted that the Council now has an opportunity to make a change and to improve the planning partnership and the relationship between this process and the community. Regarding

cultural competence, Chata said that he would go more in-depth and would work on a definition of the term. He added that he and many of his Native brothers and sisters do not see themselves as "people of color," but as a First Nation/First People. He said that he comes from a different perspective and a different jurisdiction. He expressed his sense that the Council had managed to break down/open some doors to ensure that the planning process addresses gaps, concerns, and linkages. However, he was not sure of what could be done about the current situation.

Jimmie said that he didn't plan to talk about the meeting with Dr. Katz (since he had already said all that he had to say on that topic, and he wanted to give others a chance to speak on it). He expressed some satisfaction that, at least now at the end of the year, the Roles and Responsibilities document was coming to fruition. The other task that he wanted the Council to remember would be coming up this year was the **evaluation of the resource allocation process**. He added that the committee charged with this task will contribute ideas for improving the process and communication around funding allocation, and may also have some influence on the evolution of the planning roles and responsibilities. He asked members to maintain some faith in and patience with the process, and to **speak up** at anytime that they felt their faith or patience running dry.

Roberto said that he thought the discussions around the outcomes of the planning process had continued, both inside and outside of the Council. He remarked that this process has taken a lot of time, and that Council members have not really taken control of the situation. He expressed his belief that the group could still **come together and give voice to its concerns**, and his hope that this process would not drag on without members ever coming together in this way.

Mark spoke about addressing the **gaps in services**. He said that this is a large issue, and that the Council would need to look at what happens when the gaps cannot be addressed, and at the pain that that causes service providers.

Barbara said that she feels that the Council is accomplishing things, and that it has done a great deal. She noted that, once the RFPs were released, the Council knew the problems it had to address and started addressing them, and wanted everything done immediately ("done yesterday," as she put it). She pointed out that the Council has a lot of energy, and that it is now gaining clarification on what power it has and how it may be extended. She expressed her sense that the way in which the Council works is representative of what it's like to work in this pandemic. She explained that, while many issues may still feel unfinished, **progress is being made** -- and she gave the example that people in this City will never look at RFPs in the same way again.

Ana Claire described her own sense of closure, and of seeing some new directions for the coming year of planning. She said that she had given testimony at the Health Commission meeting, and had watched with difficulty as the Commission approved the prevention contracts. She didn't feel that the funded contracts were adequate, and she said that she would talk more in March (when she leaves the Council) about some directions that the Council needs to take. Ana Claire suggested that the Council should work on its **relationship with the Health Commission**, which has not previously known much about the Council or its activities. She stressed her concerns about how the first RFP and the whole RFP process negatively affected **women at risk for HIV**. She closed by saying that HPPC members, including herself, had given testimony to the Health Commission as individuals serving on the Council, and that Chata had delivered a statement for the HPPC as a whole. The Health Commission took their input and then made their own decision.

Sacul articulated her own experience of feeling that the Health Commission had treated her, and the others who had come to give public comment, with a serious **lack of consideration or respect**. She explained that the outside speakers had been made to wait through three hours of the meeting, and had then been allotted only five minutes in which to give comments. In view of this experience, she said that she wanted people who give public comment to the HPPC to know that she had been listening to them, had taken their comments seriously and had acted on their input. She said that she sometimes feels that the people who have the funding and the contracts lack the compassion that others like herself have; while she can be forward and direct, she can also be sensitive.

Valerie asked to see whether there was consensus or a majority in the group present, in favor of closure on these issues. Maria expressed her inability to give consensus on this question of closure, because she still felt dissatisfied. Other members expressed confusion over what was being put up for a vote. For the straw poll, the co-chairs clarified that members were being asked whether they were ready to move on, and to agree to an end to the discussions in HPPC meetings about the last resource allocation process. The poll was then taken, to see whether Council members were ready to move forward, with the knowledge that processes were already in place to improve future resource allocation efforts (and that they did not have to agree with the current distribution of funds, or the way in which it was reached).

Straw Poll

In Favor:	**16**
Opposed:	**1**
Abstentions:	**3**

The motion to move on with other Council business, and to call an end to the Council discussions of the most recent RFP/resource allocation processes, was approved by a majority of members present.

9. CLOSURE FOR 1996 HPPC

At this point, the co-chairs introduced a closing ceremony for those who served on the 1996 Council. Chata and Ana Claire presented Valerie (who has served on the Council since its first year, in 1994) with a plaque honoring her for her service, and Valerie accepted with a short speech about her departure and her hopes and expectations for the Council. She expressed her passion for prevention planning, and her pride in the Plan. She asked the Council to remember, as it evaluates what it has produced, the whole picture of prevention services and of how they might change in response to revisions in the planning process. She stated that prevention is the only vaccine available against the HIV pandemic. In closing, she wished the Council members luck, and encouraged them to work hard; to be constructively critical; to keep in mind the goal of reducing new HIV infections to as close to 0 as possible; and to educate those in the Health Commission, the Board of Supervisors, the Mayor's Office, and the press about the community planning effort.

Chata then presented a plaque to Ana Claire, who said that she would address the Council at the next meeting, before she actually leaves her post as co-chair. Ana Claire presented a plaque to Joshua, who also started on the Council in 1994, making him (along with Valerie and Ana Claire) one of the longest-term members. Joshua reassured the group that he was not really going to be absent from meetings, but that he just wouldn't be able to vote anymore.

Other plaques were then presented to the continuing Council members from 1996: Chata, Barbara, Isabel, Roberto, Ellen, Jimmie, Liz, Bethsaida, Sacul, and Mark. (Those absent from the meeting

could not be given their plaques at this time.) The co-chairs also thanked the consultants and AIDS Office staff who have provided ongoing support to the Council.

The meeting had run over its expected time, and members were dismissed as soon as all of the plaques had been received.

10. MEETING EVALUATION
Members present were expected, as usual, to complete the meeting evaluation and participant dialogue forms.

Enclosed with These Minutes (for all HPPC members, consultants):

- Minutes of the 1/21/97 Health Commission meeting
- Flyer for the 2/14/97 benefit dance party for Shanti's Latino program
- Copy of the 1/23/97 BAR article (by C. Laird): "HIV Prevention Plan Lands with a Thud"
- Process Evaluation Team report overheads
- Calendar of HPPC and related committee or task force meetings in February (updated 1/23)

Enclosed with These Minutes (for those absent):

- "Evaluation Results" and "Participant Dialogue" from the 12/12/96 meeting
- Sign-up slip for the HPPC RFP-related task force that will be forming
- 1/23/97 recommendations from the Roles and Responsibilities Task Force

Separate Packet of Attachments (in the mail, for those absent):

- The MARCC focus group results and informational materials
  (These packets have already been copied by MARCC staff, and will be mailed separately with MARCC postage, so as not to draw upon the budget for HPPC logistical support.)

Next Meeting: Thurs., February 13, from 3-6pm at the First Unitarian Church -- 1187 Franklin

Minutes Recorded by: Mary Irvine
Minutes Approved by: Outgoing DPH Co-Chair Valerie Kegebein and Community Co-Chair Ana Claire Meyer

Note: Time Change!

HIV PREVENTION PLANNING COUNCIL MEETING

February 13, 1997
3:00 PM 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Gene Copello
Ana Claire Meyer
Ronnie Ashley (Chata)

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Please read: **Agenda and minutes of January 23, 1997**
***Please bring*:** **Entire Package**

Agenda

1. Welcome & Introductions	Ana Claire Meyer	3:00 - 3:05 PM
2. Announcements: Roles & Responsibilities	Ana Claire Meyer	3:05 - 3:10 PM
3. Public Comment	Gene Copello	3:10 - 3:30 PM
4. Minutes from January 23	Ana Claire Meyer	3:30 - 3:35 PM
5. Orientation	Orientation Task Force	3:35 - 4:45 PM
6. Break		4:45 - 4:55 PM
7. Membership Committee - By Laws	Christine Edwards	4:55 - 5:40 PM
8. Co-Chair Election - Nominations	Ana Claire Meyer	5:40 - 5:50 PM
9. 1997 Tasks & Committees Selection	Ana Claire Meyer	5:50 - 5:55 PM
10. Meeting Evaluation	Ana Claire Meyer	5:55 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC - Thursday, March 6, 1997, 3-6 PM, First Unitarian Church, 1187 Franklin Street (@ Geary).

HPPC - Thursday, March 27, 1997, 3-6 PM, First Unitarian Church, 1187 Franklin Street (@ Geary).

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HIV PREVENTION PLANNING COUNCIL
MINUTES
February 13, 1997

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Members Present:
Ronnie Ashley (Chata)
Isabel Auerbach
Ahimsa Timoteo Bodhrán
Gene Copello
Christine Edwards
Ellen Goldstein
Vic Hernandez
Liz Highleyman
Jelousy Jiggetts
Sacul L'Adnbre
Ana Claire Meyer
Jimmie Naritomi
John Newmeyer
Henry Ocampo
J. Colin Partridge
Dawn Passar
Bethsaida Ruiz
Steven Sams

Members Absent:
Barbara Adler
Hector Carrillo
Patrick Forte
Roberto Garcia
Jennifer Lorvick
Askia Muhammad
Mark Peppler
Joel Reyna
Maria Rinaldi
Terry Ryan
Sandy Simms

AIDS Office Staff:
Delia Garcia
Valerie Kegebein
Tracey Packer
Mike Pendo
Billy Pick

Guests:
Cynthia Laird, B.A.R.

Process Evaluation Team:
Pali Basi
Ruel Caneda
Cathleen Farrell
Cely Queiroz (new member)
Kathleen Roe
Kevin Roe

Harder + Co./Polaris/Prevention Training Center:
Martin Forst, Polaris, Inc.
Ellen Irie, Harder + Co.
Mary Irvine, Polaris, Inc.
Lyn Paleo, Harder + Co.
Stacy Vogan, HIV/STD Prevention Training Center

1. WELCOME & INTRODUCTIONS

Members, guests, AIDS Office staff, and consultants present introduced themselves in order around the room. Prior to the meeting, Joel Reyna had called the AIDS Office to say that he would be unable to attend, due to a family emergency.

2. ANNOUNCEMENTS

Ana Claire Meyer:

- The Roles and Responsibilities Task Force has been meeting and working, and hopes to have a draft document ready by the end of March. Ana Claire noted that the next meeting, originally set for February 27th, would have to be re-scheduled by the members present at the end of this meeting. (Note: The next meeting of this task force will take place on March 7th, from 9:30am-1pm.)

- On the topic of membership, Ana Claire noted that there have been two recent resignations from the Council: Natalie Gutierrez (whose letter of resignation was distributed at this meeting and is enclosed for those absent) and Gregory Walker. (Note: Since this meeting, Terry Ryan has also formally resigned from her seat.) Ana Claire informed the group that the current membership of the Council is at 26, and that the maximum number of members is supposed to be 37. She said that the co-chairs had decided not to fill the 11 open spots yet, and to continue functioning with 26 members instead. They had agreed that it would be more difficult to bring on 11 new people at this point without an orientation than it would be to keep operating at the current level of membership. Since an orientation had just been organized and done for this Council, it would be too difficult and time-consuming to pull together another such event now. Ana Claire added that the nominations process would begin with an announcement going out in mid-March, for new members to start their terms on May 15th.

  Steven asked why all of the available spots were not filled during the last round of member selections. Ana Claire explained that four spots could not be filled because of the lack of nominations for some slots reserved for the representation of particular groups: (1) one seat is still open for an SFUSD representative, (2) one spot is still open for a youth, and (3) two spots are still open for HIV-positive persons. On Steven's request, Ana Claire agreed to distribute with the minutes a list of those members who had left the Council since the selections made in the late fall of 1996. (Note: Since Brian Dobrow has been out of town and a list is not yet ready, it will be distributed separately from these minutes.)

- {**Note from Ana Claire:** At this meeting, it should have been announced that the HPPC co-chairs and Valerie Kegebein (as the Chief of the HIV Prevention Planning & Policy Unit of the AIDS Office) had submitted letters to the B.A.R., to address the article, published in the B.A.R. on January 23rd, on the San Francisco HIV Prevention Plan. These letters of response, appearing in the February 13 issue of the B.A.R., are enclosed with these minutes for anyone who may not have been able to read them in the paper.}

Brian Dobrow:

- Brian reminded the group that he was recruiting volunteers for the National AIDS Update Conference, to be held at the Civic Auditorium from March 19th through March 21st. The volunteers will work four-hour shifts providing directions for those who are registered, and/or serving as room monitors. Volunteers completing a four-hour shift will be entitled to a free conference registration for the rest of the day. All those interested in volunteering at the conference should contact Brian Dobrow by phone (554-9499) or fax (431-7547) at the AIDS Office. In response to a question about the schedule of workshops and speakers for the conference, Brian explained that a schedule had not yet been issued.

- Brian also summarized the information in his recent memo to the Council on photographs taken by the press. He explained that members of the press are entitled to take photographs at the Council meetings, but that particular members of the Council may request that they not be photographed, and these requests must be respected.

Valerie Kegebein:

- Valerie told the Council that Mary Irvine had been accepted into Columbia's School of Public Health. (Note from Mary: I will probably leave for New York at the end of June;

but will first train another Polaris staff member to provide logistical support for the remainder of the planning year. My relationship with the Council has, with good reason, been highly coveted by other junior staff at Polaris.)

3. PUBLIC COMMENT
There was no public comment offered at this meeting.

4. MINUTES FROM JANUARY 23
Steven asked about the attribution of a question paraphrased under the **"Question and Answer"** section on page 6 of the minutes. Ana Claire, who had answered the question at that meeting, stated that she thought it was correctly attributed in the minutes. With no further discussion, the minutes of 1/23/97 were approved without exception and by consensus (15 of the 15 voting members present at this time were in favor of the approval of the minutes).

During this vote, the co-chairs clarified that new members were now empowered to vote. The co-chairs apologized for not having mentioned this change in the announcements; this was the first official meeting of the 1997 Council, and thus the first meeting at which the new members could vote.

5. HPPC LETTER OF SUPPORT FOR "VIRAL BRIDGES" CONFERENCE
Ana Claire introduced this addition to the agenda. J. Colin Partridge briefly described the proposed "Viral Bridges" conference to be held in March of 1998, at Sonoma State University. Having sent Valerie Kegebein a letter of request for HPPC support, J. Colin distributed at this meeting a draft format for the HPPC letter of support (enclosed for those absent). He explained that the proposals for this CDC grant would be due the next morning at 9am, and that he and Assisant Professor Robert McNamara of S.S.U. had wanted to help expedite the process, should the HPPC agree to contribute a letter of support. He noted that he was not invested in the specific text of the draft letter, and that it could certainly be revised to suit the Council.

Dr. Partridge said that the conference would offer comparisons of the risk groups in Sonoma with those in San Francisco County, and would include discussion of ways in which to better implement the HIV prevention plans of both counties. He added that, following the approval of a letter to accompany this proposal, he would assess the level of support in the Council for the participation of its members in panels and small group discussions at the conference.

At this point, Ellen motioned for an HPPC letter of support for this conference proposal. Chata seconded the motion. Gene asked whether the Sonoma prevention planning council had agreed to write a letter of support; J. Colin replied that it had.

The Vote	
In Favor:	**14**
Opposed:	**0**
Abstentions:	**2**

With the motion for an HPPC letter of support passed by consensus, the co-chairs agreed to prepare the letter (on behalf of the Council) in time for the proposal submission the next morning.

6. ORIENTATION

Part 1: Brian Dobrow on Parliamentary Procedure

Brian distributed handouts on Robert's Rules of Order and "Bobby's Rules of Order," which he explained as an adaptation of Robert's Rules to fit the HPPC. He explained that the purpose of "Bobby's Rules" was to make a procedure for group decision-making that would become a part of the Council's regular functioning, and that would not intimidate members or require a great deal of memorization. Brian then initiated a brief "Bobby's Rules" exercise (with Ana Claire, Chata, Ellen, and Lyn playing assigned roles), during which he explained the particular actions taking place.

The exercise, which became slightly more complicated than its outlined script (enclosed for those absent), illustrated the following procedural points:

- ⇒ A second amendment to a motion cannot be discussed until/unless the first amendment has received a vote and has not passed.
- ⇒ A "substitute motion" can be made after an original motion, and takes precedent over any other discussion (e.g., of amendments to the first motion).
- ⇒ The maker of a motion can always withdraw his/her original motion and, if interested, make a new one. Then the Council is required to drop the original discussion and turn to examine the new motion.

At the close of the exercise, Brian pointed out that the intent behind the rules of order is to keep the process simple and inclusive, to try to achieve consensus, and -- if consensus cannot be achieved -- to carry the group through a vote.

Question and Answer

Jimmie mentioned a difficulty that he saw with the process shown in the exercise. He explained that, in his understanding, any amendment has to address the original motion. In the case of the exercise, this would mean that the motion to have only Middle Eastern food at meetings could not be amended to stipulate that only Mexican food would be provided at the meetings. Brian agreed with Jimmie's point that the Council has to act on the original motion first, *unless a substitute motion is proposed.* Regular amendments can be proposed as changes to a more general motion, but not as direct contradictions to it.

Sacul asked where in the procedure there would be room for a new idea. Brian responded that a new idea could be presented in the form of a substitute motion, which would receive a vote first -- causing the first motion to be deferred for a vote that would happen only if the substitute motion should fail to be passed.

Brian informed the Council that he would be acting as the parliamentarian at future meetings, but that members would be welcome to step in with their own questions or clarifications about parliamentary procedure. He added that, at any time that a member needs more information before voting, she/he can speak up to request a "point of information," in her/his own words (e.g., "What's going on?" or "I need clarification."). He stressed that it is important for members to understand the kinds of decisions that they are being asked to make, and to get any answers they may need before making a decision.

J. Colin clarified that a substitute motion takes the process back to the top of the "Bobby's Rules" diagram. Brian confirmed that this is the case.

Part 2: Christine Edwards on HPPC Meeting Expectations
Using an overhead projector, Christine read through and expanded upon some notes on the expectations of the San Francisco HIV prevention planning process participants. (The text of the overheads is enclosed for all absent members.)

Question and Answer
Ahimsa asked for an explanation of the term, "concept vote." Ana Claire responded that a concept vote happens when a committee or other working group within the Council brings draft information on its recommendations to the full Council, and the Council votes on whether it agrees with the direction that the group is taking. Concept votes are put on the agenda prior to the final votes on the same issues, so that the Council members have a chance to read the materials in question and to form and express their opinions and suggestions for any needed changes. The concept votes also serve to let committees or other working groups know whether they are pursuing recommendations that the Council will support, and they allow time for necessary revisions. As Ana Claire pointed out, there is also a brief discussion of the use of the concept vote in the minutes of the 1/23/97 meeting (pg. 6, at the top).

Christine distributed handouts on the ground rules for Council participation and on the steps that members can take when they have questions, concerns, or other issues related to the HPPC work. Ellen mentioned that new members had asked her some questions about the HPPC meeting process, and she requested that the other overheads also be included in the minutes packets for members' reference. (The two one-page handouts mentioned above, along with the other notes displayed on the overhead projector, are enclosed for all HPPC members in a single stapled packet for this presentation.) Steven pointed out a typo on the page of "General Expectations": the parenthetical statement about those living with a life-threatening disease should begin with the word "exceptions," rather than "expectations."

Part 3: Lyn Paleo on the Prevention Plan, and on Consultant Support to the Planning Process
Lyn explained that the technical support team does not usually speak at meetings, so that this presentation was a special opportunity for her to address the Council. She emphasized that the consultants feel that their work on this process is important, in that they can save the committee and Council members time, freeing them up to make the critical decisions of prevention planning. The technical support team gathers research information, finds and summarizes documents of use to the process, provides writing and wordsmithing, and responds to other kinds of requests from the Council and its committees/task forces. At the end of the process, the consultants take the work of the Council and put it into words, making the text of the Plan. Lyn said that she was honored and grateful to be able to join the Council in the work of planning. This year, Ellen Irie and Steven LaFrance of Harder + Co. will work on committees, and Oscar Trujillo will be contributing in the background, from the office. Mary Irvine of Polaris, Inc. will continue to take and distribute the minutes at most meetings, and will also continue to arrange for the refreshments. The provision of logistical and technical support services allows the Council to focus on setting the policies for local prevention.

On the topic of the Plan, Lyn explained that she would have to be brief, given the limits to the time on the agenda. Using the overhead projector, she shared some notes on highlights of the Plan. (These notes are enclosed for all members.) She informed the group that she would be taking a dual approach to discussing the Plan: (1) from the middle outward, and (2) in the order in which the Plan is written.

Question and Answer
Ahimsa asked about the term, "seroprevalence," and Lyn explained that it refers to the percentage of people with HIV in a given population.

Steven asked if the numbers in the Plan had been pulled from the articles found in Harder + Co.'s literature search. Lyn responded in the affirmative. Then Steven asked whether these numbers had been taken from reporting (e.g., self-reported behavioral frequencies), from interviews, or from another source. Lyn replied that the numbers were estimates based on the data from a number of studies (all cited as sources in the Plan). She stressed that these numbers should be viewed on a broad-brush scale, and not as precise figures. These were the best estimates that the consultants, committee, and Council could provide at this time. Lyn noted that it is hoped that the Behavioral Risk Assessment will yield much more useful, accurate data -- based on specific client populations. Gradually, providers' own data will be added to the data available in the existing literature, to produce a clearer picture of risk levels in San Francisco populations. Steven suggested that the available data provides more information from the perspective of HIV-positive persons than from the perspective of HIV-negative persons. He identified a need, for the purposes of prevention, to use data on HIV-negative people and their risks. Lyn stated that the Plan had used some comparative studies (describing which behaviors are more likely to lead to HIV infection), as well as a broad survey source on how many times the members of particular population groups have sex (The Social Organization of Sexuality: Sexual Practices in the United States). Ellen added the point that the available literature is slim, when it comes to describing specific behavioral risks for different populations. She explained that the data sets are generally not matched.

Steven suggested that, in the next year, he would like the Council to look at the data comparing risks by population type, and to consider how this information should influence the next round of prevention funding. Ana Claire replied that this constitutes a task for one of the 1997 HPPC committees, which the Council would be discussing soon.

Ahimsa asked whether a prevalence study finds the percentage of people in a given population who are HIV-positive (Lyn responded affirmatively), while an advanced risk behavior study finds the frequency of risk behaviors in a population. Lyn explained that an advanced risk behavior study may look at frequencies, but that it tends also to probe into the reasons for a population's elevated risk -- in other words, "What's going on?" and why/how it is increasing risk for HIV.

In closing, Lyn directed the group's attention to the stapled handout, "The 1997 San Francisco HIV Prevention Plan," distributed at this meeting (and enclosed for all absent members). This document shows the main questions answered in each section of the Plan, and the exact pages on which the answers can be found. It can be used as another easy-reference document for members. Lyn stated that each HPPC member is expected, at a minimum, to read the introductory chapter to the Plan, the final chapter (with the synthesis and future directions), and whatever chapter is relevant to the work of their particular committee. However, it is hoped that members will read more than the bare minimum expected of them; for example, it makes sense for all members to know the basic goals and objectives for the overall planning process.

Ana Claire added that the Council will continue to have discussions of the Plan throughout the year, as issues relevant to the Plan arise.

Part 4: Kathleen Roe on the HPPC Process Evaluation

Kathleen began her introduction with a statement clarifying the distinction between process evaluation and other types of evaluation. She described process evaluation as providing an account (from within a process, or from an outsider's perspective) of how a process happened. Outcome and impact evaluation, which can be defined differently in different contexts, are generally understood as "higher" forms of evaluation, which show the results of a process and its range of effects.

The HPPC Process Evaluation Team (Kathleen Roe and Associates) was hired to give a process evaluation of the San Francisco planning effort, and to track the implementation of the following CDC planning group principles:

1) *Parity:* Everyone on the Council has an equal vote.
2) *Inclusion:* Groups must find ways of operating in order to include everyone (e.g., Bobby's Rules).
3) *Representation:* People on the Council must represent the HIV/AIDS epidemic and the diversity of the local community.

Speaking to the issue of representation, Kathleen Roe described the first-year (1994) Council as having had more researchers, while the third-year (1996) Council more heavily represented CBOs. She described the 1997 membership as striving for a balance between those areas of representation. She stated that the nominations are solicited and then considered with the criteria for representation in mind. She also pointed out that representation involves bringing planning information and concerns back and forth between the Council and the city's communities.

Kathleen Roe explained that the Process Evaluation Team gives the Council feedback, about 90% of which comes from members, on how well it is succeeding in providing *parity, inclusion, and representation.* The evaluators are constantly distributing and collecting forms for HPPC members' input and comments, and they also conduct interviews at various points in the process. They regularly present the combined information back to the Council as a whole, and create succinct summary documents when necessary. Kathleen pointed out that members can, through the process evaluation methods, express concerns and thoughts that might not as easily be expressed during actual meetings.

Using overheads (copies enclosed for all HPPC members), Kathleen addressed the reasons for participating in the process evaluation, the ways in which the evaluators give information back to the Council, and the ways in which members can participate. She explained that, since not everyone has fax capability or e-mail, the evaluators have to rely on paper, and that they use a lot of differently-colored sheets in order to distinguish their different forms. (Excess forms brought to meetings are re-used, however, in the production of the minutes packets.)

Stressing that the evaluation documents are a matter of public record, Kathleen requested that members offer constructive and kind comments, rather than comments that are either flirty or mean-spirited. She noted that members have the option of highlighting any comments that they want to keep confidential, meaning that -- if the desire of the member for confidentiality is clearly communicated on the evaluation form -- those comments will be conveyed only to the person for whom they are intended, and will not go out in the results issued to the Council and consultants.

Using Ellen's behavior at this meeting as a positive example, Kathleen told members that they could keep their evaluation forms out and jot comments down during the meetings, so as not to lose thoughts that might be forgotten by the end of the meeting.

Kathleen introduced a new evaluation form to be used regularly in this process: the "Community Outreach" page. In this space, members will be asked to record any important issues that may have come up in conversations they have had with people within or outside of the planning process. The "Community Outreach" page will inform the evaluators and the rest of the Council about what Council members may know through their community contacts, and about whether this group is truly being representative. The use of input on these forms may help to prevent the kind of surprise that Council members have sometimes experienced over the public response to the Council's work.

Kathleen Roe then requested that all members turn in their "Background Experiences" questionnaire by Monday, February 17th.

Finally, Kathleen mentioned the end-of-year reports produced by the Process Evaluation Team. She noted that she had recently reviewed the Year 1 Evaluation, and had found that the recommendations from the end of that report were almost identical to the recommendations that she would make now. Because she sees the basic issues as having carried over from year to year, she included the Year 1 (1994) recommendations in a handout for the 1997 Council: "Discussion and Recommendations -- Selection from Year 1 Process Evaluation" (enclosed for those absent).

Question and Answer
Steven asked what would happen if members asked, through the forums provided by the process evaluation, for action -- but that action then did not happen. Kathleen Roe responded that the requests would make it into the public record of the Council. Once such requests have been entered in the public record, it becomes the responsibility of the Council members to track progress on meeting them, and to bring them up again as necessary. She added that the Process Evaluation Team members would also provide some coaching, to ensure that objectives are being met in a timely manner.

7. BREAK

8. MEMBERSHIP COMMITTEE -- BYLAWS
Christine presented the Membership Committee's recommended changes to the ByLaws, as shown in the copy (preceded by a memo dated January 31, 1997) that was recently mailed out to the full Council membership. Extra copies of the proposed revisions were distributed to those present. Christine noted that she would be going over the changes section by section and article by article.

Article III - MEMBERSHIP, Section 1
This change -- specifying that HPPC membership, "...with the exception of the representative of the State Office of AIDS, shall be restricted to persons who currently reside in or work in the city of San Francisco..." -- required no discussion by those present. A motion was made and seconded for the approval of this first revision to the ByLaws.

The Vote

In Favor:	**16**
Opposed:	**0**
Abstentions:	**0**

The revision to the text of Section 1, Article III carried by consensus.

Article IV - NOMINATIONS, Sections 1-4
The change to Section 2 omits the mention of the "Chief of the Prevention Planning, Policy and Health Education Unit of the AIDS Office" as the person who solicits technical experts for Council membership. The reasoning is that this position, occupied by former HPPC Co-Chair Valerie Kegebein, would not be the only one appropriate for solicitation of technical experts.

Discussion
Isabel noted that this deletion leaves a sense of vacancy in the sentence, and a question as to who is responsible for this task. Brian responded that the solicitation is handled by AIDS Office staff, but that it did not seem helpful to try to specify exactly who in the AIDS Office would do it. Ana Claire offered that the committee could try to specify how the solicitation is done, if that might make the sentence seem more complete. Isabel replied that this would not be necessary.

Steven stated that the total of the numbers of governmental representatives, technical experts, non-governmental representatives, and community representatives that could sit on the Council (39) currently comes to more than the maximum number of Council members (37). Christine explained that a smaller number of representatives in a particular group was acceptable, and that the ByLaws simply require that there be "no more than" a certain number of members from each group. Steven suggested that a reiteration of this point somewhere else might clarify it; he preferred the addition of some wording about the number "totaling" no more than 37, or no more than the number specified in Article III, Section 1. Ana Claire reminded the group that such new proposals for revisions to the ByLaws would have to be submitted to the committee for review and approval, before coming back to the Council for a vote at a later meeting. Council members must always have warning of any proposed changes to the ByLaws, prior to the meeting at which those changes will be discussed and decided. Ana Claire also assured the group that the co-chairs would never make the mistake of allowing for the appointment of more than 37 members to the Council.

Speaking about Sections 1-4, Jimmie pointed out that there must be a limit on the number of people appointed from each representative group, but that there does not have to be a limit on the number solicited/nominated. While an *appointment* places someone in a seat, thus limiting the number of other appointments that can be made, a *nomination* does not indicate pre-approval for membership. Ana Claire responded that this was a valuable point, and stated that, at this stage, the first four sections under this article would have to be sent back to the committee. Jimmie added that the committee should consider deleting the last sentence under Section 1, regarding the non-voting ex-officio member of the HPPC, since Gene Copello has become the DPH co-chair. The co-chairs acknowledged this point as well, and observed that there appeared to be consensus in the Council that **Sections 1-4 of this article would be returned to the committee** for further revisions.

Article IV - NOMINATIONS, Section 5
Christine read through this entire section, which explains the functioning of the nominations pool. Brian elaborated, stating that the intent behind the nominations pool was to create a list in the first selections process of persons eligible for consideration in the second selections process for that year. In other words, people who have been nominated in the first process will not need to be re-nominated in the second. An interested individual should apply for membership only once per year. He noted that the HPPC had never had an official, working nominations pool in the past.

Discussion
Steven asked if this pool could be used to fill newly-opened vacancies on the Council. Ana Claire responded that it would be used, but that the selections process to fill such vacancies would also be opened up to people outside of the pool. Liz stated that she liked the concept of the pool as a means of filling mid-term vacancies -- in other words, as a list of alternates. Christine responded that the pool would serve both purposes -- as a list of alternates, and as a set of eligible persons to be considered again in the second selections process for a given year. Liz gained clarification that the people in the nominations pool would still have to go through a process of selection, following their entry into the pool and prior to their actual appointment to the Council.

Vic asked about the reasons for non-selection of some nominees. Brian responded that those not selected may not have fit the criteria for membership, may have been nominated for the wrong type of slot on the Council, or may simply not have been chosen as a result of the sheer number of nominees for the particular slot. However, Brian explained, those fitting into the latter category would now be made part of the nominations pool, for consideration in the next cycle of selections.

Jimmie asked whether the wording in this section, about the list remaining active for six months, was reasonable. He wondered whether the existing list would still be valid, for example. Brian replied that he saw the expectation expressed in this section as one that could be met; the Membership Selection Committee should be able to convene every six months. Thus, the list from the last selections process would still be in use at the time of the next selections process (though not beyond that time). Ana Claire responded to Jimmie's question by explaining that the Council would not be continually supplementing its membership from the nominations pool alone; there would still be a regular selections process every six months. Brian added that, while the Membership Selection Committee found that it was not feasible to convene on a quarterly basis, it did manage to convene about once every six months.

The Vote

In Favor:	**15**
Opposed:	**0**
Abstentions:	**0**

The new text shown for Section 5 of Article IV carried by consensus.
(Note: It seems that, for this vote, someone left the room or abstained without raising their hand.)

Article V - APPOINTMENT, Section 1
The revision to this section clarifies that the Membership Selection Committee must include "at least two" of the Mayor's HSPC co-chairs, as well as including at least two HPPC co-chairs.

Discussion
Jimmie began to express a concern about another piece of this Section, but was asked to hold his question and to submit it to the committee, for a later process of revision. Since no discussion was required on the specific change mentioned above, a motion was made and seconded to approve it.

The Vote

In Favor:	**13**
Opposed:	**0**
Abstentions:	**3**

The revision to Section 1, Article V was approved by consensus.

Article V - APPOINTMENT, Section 2
The change to this section indicates that, from this point onward, all membership terms will begin on January 1st or August 1st of each year.

Discussion
Steven quickly asked for clarification on whether the two-month provisional period would count as part of the term (beginning on January or August 1st). When he was informed that it would not (the provisional/orientation period precedes the official beginning of a member's term), he said that the revision made sense. The motion to approve the additional text was made and seconded.

The Vote

In Favor:	**16**
Opposed:	**0**
Abstentions:	**0**

The motion in favor of revising the ByLaws to set the future starting dates of membership terms for January 1st and August 1st passed by consensus.

Article V - APPOINTMENT, Section 3
The revisions to this section refer to the January 1st and August 1st starting dates of membership terms, as they relate to the filling of positions vacated between November 1st and August 1st, or between August 1st and November 1st. The last addition to this section refers the reader back to Article V, Section 1, for a description of the makeup of the Membership Selection Committee.

Discussion
Liz suggested that it might be valuable to set a membership "floor" (minimum number of members) beneath which the Council could fill empty slots without having to wait for the next six-monthly selections process. She added that she was concerned about the problems that the Council had been having with achieving a quorum. Ana Claire responded that the problems of achieving a quorum can usually be solved simply by terminating the memberships of those who have not been attending meetings. The actual quorum adjusts to the number of members on the Council (it just requires more than one-half of the actual members to be present for a vote). Christine added that the Council had previously discussed the possibility of setting a floor for membership, and that the idea had been rejected. The motion was then made and seconded to approve the proposed revisions to this section of the ByLaws.

The Vote:

In Favor:	**14**
Opposed:	**0**
Abstentions:	**2**

The revisions to Section 3, Article V were approved by consensus.

Article V - APPOINTMENT, Section 4
The addition of this text offers an exception to the residential/employment requirements, for those members who undergo a change in status, following their appointment to the Council (to allow such members to serve out the remainder of their term). There was no discussion of the new section. A motion was made and seconded to approve its incorporation into the ByLaws.

The Vote

In Favor:	**15**
Opposed:	**0**
Abstentions:	**1**

The motion to include this new text in the ByLaws was approved by consensus.

Article VI - OPERATING PROCEDURES, Section 1
This section includes changes (1) to allow for a DPH co-chair who may not be in the HIV Prevention Planning, Policy and Health Education Unit, but who does have "HIV prevention responsibilities in the AIDS Office," (2) to extend the community co-chair's role beyond the two-year term, for an interim period lasting until the end of March, (3) to stipulate that the Council must elect its new community co-chair from among individuals who have served at least one full year on the HPPC (by the end of January), and (4) to state that that new co-chair will be mentored by the outgoing community co-chair through the end of March of that year.

Discussion
Chata spoke up to say that he did not remember the Membership Committee ever having reached a vote or a consensus on the omission of the old language about the AIDS Office position held by the person to be appointed as the DPH co-chair of the HPPC. He said that AIDS Office Director Mitch Katz had decided to appoint a co-chair, without the consensus of the Membership Committee on the ByLaws revision needed to allow for that appointment. He stated his feeling that this action occurred in violation of the community planning process. Gene replied that (a) the AIDS Office unit in question no longer exists as such, and (b) he believed that Director Mitch Katz viewed the role of supervision over the unit as filling the same requirements that the role of a unit staffperson would fill, for the purposes of the community planning process. Chata stated that he did not think it fell within the purview of the AIDS Office to change the ByLaws. Ana Claire expressed her concern that the allusion to "HIV prevention responsibilities" was too vague, and would require clarification. In view of these issues, a motion was made and seconded to **return to the committee** this revision of the language about the position of the AIDS Office co-chair. The vote on this motion, regarding just this first piece of Section 1, follows.

The Vote

In Favor:	**14**
Opposed:	**1**
Abstentions:	**1**

The motion to return this revision to the committee for further consideration passed by majority. In response to a request from Vic, the committee also agreed to check the entire ByLaws document to ensure the elimination of any names now out-of-use for units of the AIDS Office.

Regarding the extension of the community co-chair position and voting privileges through the end of March (following the completion of the regular two-year term), Chata requested the addition of a phrase saying, "...or until a new community co-chair is elected." Liz asked what would happen with the mentoring period for the new co-chair. Ana Claire responded that she wanted to change the phrasing of the ByLaws around mentoring, to account for the possibility of a delay in the election of the new community co-chair. Chata expressed his hope that the co-chair election would happen on time in the future. Jimmie suggested that the language should clearly state, "... ending on March 31st," rather than referring generally to the end of March. In light of these suggestions for revisions, a motion was made and seconded to return this altered portion of Section 1 to the committee as well. Ana Claire added that she would like the language to specify that the outgoing community co-chair's role would be terminated at the end of one month from the time of the new co-chair's election. Members turned to discuss the next piece, before voting on the above motion.

In the third altered piece of Section 1 (discussing the election and mentoring of the new community co-chair), Council members noticed that they were dealing again with this question of when exactly the outgoing community co-chair's term would end. Ana Claire recommended approving the revision as it stood, with the understanding that the committee would change the specific language later. Steven spoke up to say that he could accept the revision in this conditional manner, as long as there would definitely be wording to allow for the mentoring stage. Ana Claire explained that, **without a temporary acceptance of this revision to the ByLaws, nominations could not be accepted for the community co-chair position** -- because of the lack of clarity on whether nominees would have to have served for a full year or not. Jimmie suggested moving the election up to January, with mentorship to follow in February/March. It was then clarified that that was the intent behind the current revision, which sets a deadline for the transition from the outgoing to the incoming community co-chair. At this point, a motion was made and seconded to accept the entire second half of Section 1 (starting with, "A community co-chair who has reached the end..."), as revised.

The Vote

In Favor:	**13**
Opposed:	**0**
Abstentions:	**3**

The motion to accept these revisions, which will be wordsmithed further by the Membership Committee in response to Council members' concerns, passed by consensus.

Article IX - GRIEVANCE PROCEDURE, Section 1

The first proposed change to this section identifies the position of the Prevention and Health Programs and Policy Branch chief (Gene Copello) as the first-level arbitrator, for disputes that cannot be resolved by the HPPC, its co-chairs and the prevention unit staff of the AIDS Office. The second change indicates that, if a dispute cannot be settled even with the assistance of the first-level arbitrator, a professional mediation service will be called upon to intervene -- after which, if necessary, an appeal will be sent to the director of the DPH (Sandra Hernandez).

Discussion

Jimmie pointed out that, when the decision was made to assign the responsibility of first-level arbitration to the Prevention and Health Programs and Policy Branch chief, Gene Copello had not yet been appointed as the DPH co-chair. He stated that the simultaneous functioning of one person

in these two roles would create a conflict of interest. Gene indicated his agreement with Jimmie's point, saying that his title would need to be removed from the section about first-level arbitration.

Chata expressed his sense that some problems arising in the planning process might not be best settled between the HPPC and the AIDS Office unit staff, since there may be larger issues of implementation -- going beyond the actions and responsibilities of the prevention unit staff. He suggested that the HPPC might benefit from the addition of a community board or another means of guidance and oversight.

In response to a question from Steven about how the mediation service would be obtained, Lyn explained that the committee already has information on this service, which would become available to the Council on request. Steven asked that some of this information be specified in this section of the ByLaws. Jelousy asked whether the "professional mediation service" could refer to a lawyer, and Ana Claire answered that the existing phrase could mean anything.

Jimmie recommended that another step be added to this section on grievance procedures, to involve some AIDS Office management staff, prior to the referral of the matter to the director of the DPH. In light of these several concerns about the revisions to this section, the motion was made and seconded to **return the work to the committee for re-tooling.**

The Vote	
In Favor:	**16**
Opposed:	**0**
Abstentions:	**0**

The motion to return the revisions on Section 1, Article IX to committee was passed by consensus.

Article V - OPERATING PROCEDURES, Section 4.5
With the discussion and voting on the Membership Committee's proposed revisions concluded, Vic asked about a new possibility for the section on exemptions from attendance requirements (not revised by the committee in this draft). He wondered whether there might be some possibility of having proxies to represent those members unable to attend meetings as a result of living with HIV/AIDS (or other life-threatening illnesses). Ana Claire suggested that Vic either consider sitting on the 1997 Membership Committee and participating in the revision of the ByLaws in that manner, or consider contacting the committee chair (to be elected) with his concerns and recommendations.

9. CO-CHAIR ELECTIONS -- PREPARATION
Ana Claire distributed the list (enclosed for those absent) of members eligible for election to the position of HPPC community co-chair -- which, with today's vote, must be filled by someone who has served on the Council for one full year. Ana Claire announced that the actual vote would take place at the Council meeting on March 6th, and that nominations would be open until Wednesday, February 19th. She asked interested nominees to fax a bio. and personal statement to Betty Chan Lew at the AIDS Office (Fax: 431-7547) by that date.

Discussion
Jimmie stressed the need for a gender balance among the co-chairs. He reminded the Council that the other two co-chair positions are currently occupied by men.

Sacul explained that she would not be able to attend the meeting on March 6th, and that she would like to nominate Ellen Goldstein at this opportunity. Ellen was asked if she would accept or would prefer to ponder the matter. She responded that she accepted, and would also ponder. She was reminded to send in her bio. and personal statement, in order to be considered as a candidate.

10. 1997 TASKS & COMMITTEE SELECTIONS -- PREPARATION
Ana Claire introduced the handout on "Tasks of Committees" for 1997 (enclosed for those absent).

Discussion
Ellen said that she saw a gap in the committees, in that there was no apparent task to hold a discussion about the standards of prevention in the City of San Francisco -- using service provider expertise to come up with recommendations about what needs to happen. She felt that it would be valuable to have a level of dialogue beyond the RFP and assessments, to look at the larger questions around the quality of prevention in the city. She said that she would want to invite community input on this task, and to find out how people are currently conducting prevention. Ana Claire responded that Ellen seemed to be proposing a broader topic, as opposed to a task with a specific product. Ellen clarified that she would want a committee to be given the responsibility of helping to organize these conversations -- for example, planning the topics, the schedule and the attendees/invitations for a conference on standards and practices of prevention. The committee would provide the structure for ensuring that this level of discussion takes place in 1997. Steven expressed support for Ellen's idea. Liz suggested that a task force (rather than a long-term committee) might be better suited to take on this responsibility. Ana Claire said that the task could be given to the Membership Committee, and noted that the Council would discuss the matter again.

Enclosed with These Minutes (for all HPPC members):

- Letters to the B.A.R., from the co-chairs and from Valerie Kegebein, regarding the Plan
- Packet of notes from Christine's presentation on expectations of the planning participants
- Packet of notes from Lyn's presentation on the Plan -- its purpose, principles, and contents
- Packet of notes from Kathleen's presentation on the HPPC process evaluation

Enclosed with These Minutes (for absent members):

- Flyer for the Castro Lions Club Youth and Community Activities Fund Project
- Natalie Gutierrez' letter of resignation from the Council
- Draft letter of support (from the organizers) for the "Viral Bridges" conference proposal
- "Robert's Rules of Order" handout
- "Bobby's Rules of Order" diagram, and the demonstration "Exercise" for Bobby's Rules
- "The 1997 San Francisco HIV Prevention Plan" handout -- questions answered in the Plan
- "Evaluation Results" and "Participant Dialogue" from the 1/23/97 meeting
- "Evaluation Results" and "Participant Dialogue" from the 1/16/97 Orientation
- "Thoughts After the Orientation"
- Blank "Community Outreach" form
- "Discussion and Recommendations -- Selection from the Year 1 Process Evaluation"
- Memo: "New HPPC Community Co-Chair"
- Handout on "Tasks of Committees -- 1997"

Next HPPC Meetings: ♦Thurs., March 6, 3-6pm at the First Unitarian Church (1187 Franklin)
♦Thurs., March 27, 3-6pm at the First Unitarian Church (1187 Franklin)

Minutes Recorded by: Mary Irvine, Polaris, Inc.
Minutes Approved by: AIDS Office Co-Chair Gene Copello and Community Co-Chair Ana Claire Meyer

HIV PREVENTION PLANNING COUNCIL MEETING

March 6, 1997
3:00 PM 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Gene Copello
Ana Claire Meyer
Ronnie Ashley (Chata)

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Please read: **Agenda and minutes of February 13, 1997**
***Please bring*: Entire Package**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Welcome/Introductions/Announcements	Chata	3:00 - 3:05 PM
2. Public Comment	Chata	3:05 - 3:25 PM
3. Minutes from February 13	Chata	3:25 - 3:30 PM
4. AIDS Office Update	Gene Copello	3:30 - 3:45 PM
5. Community Co-Chair Election	Gene Copello	3:45 - 4:00 PM
6. EXPLORING THE PLAN: Small Group Discussion	Christine Edwards	4:00 - 4:45 PM
7. Break		4:45 - 4:55 PM
8. Process Evaluation Report	Kevin Roe	4:55 - 5:05 PM
9. HPPC Committees for 1997: Panel Presentation	Christine Edwards	5:05 - 5:35 PM
10. Committee Selection	Members	5:35 - 5:55 PM
11. Closure/Evaluation	Kathleen Roe	5:55 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC - Thursday, March 27, 1997, 3-6 PM, First Unitarian Church, 1187 Franklin Street (@ Geary).

DPH

HIV PREVENTION PLANNING COUNCIL
MINUTES
March 6, 1997

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Members Present:
Barbara Adler
Ronnie Ashley (Chata)
Ahimsa Timoteo Bodhrán
Gene Copello
Roberto Garcia
Ellen Goldstein
Vic Hernandez
Liz Highleyman
Jelousy Jiggetts
Ana Claire Meyer
Jimmie Naritomi
John Newmeyer
Henry Ocampo
J. Colin Partridge
Dawn Passar
Mark Peppler
Joel Reyna
Bethsaida Ruiz
Steven Sams

Evaluation Team:
Pali Basi
Ruel Caneda
Cathleen Farrell
Cely Queiroz
Kathleen Roe
Kevin Roe

Members Absent:
Isabel Auerbach
Hector Carrillo
Christine Edwards
Patrick Forte
Sacul L'Adnbre
Jennifer Lorvick
Askia Muhammad
María Rinaldi
Sandy Simms

AIDS Office:
Kristen Clements
Brian Dobrow
Delia Garcia
Valerie Kegebein
Tracey Packer
Mike Pendo
Billy Pick

Harder + Co./Polaris, Inc.:
Ellen Irie
Mary Irvine
Lyn Paleo

Guests:
Michael Discepola, AHP
Cynthia Laird, B.A.R.
Stacy Vogan, STD/HIV Prev. Training Ctr.
Hank Wilson, ACT UP Golden Gate

1. WELCOME & INTRODUCTIONS
Chata welcomed everyone to the meeting, and all present introduced themselves around the room.

2. PUBLIC COMMENT
Hank Wilson of ACT UP Golden Gate spoke about the ten-year anniversary of ACT UP. He distributed a flyer (enclosed for those absent) for the benefit birthday dinner/party being held on March 10th at the Most Holy Redeemer Church bingo hall at 18th and Diamond. The benefit donations ($10/person) will be used to enable ACT UP Golden Gate volunteers to return to Wall Street, the site of the first ACT UP demonstration, to participate in the "Crash AIDS Profiteering!" Anniversary Action on Monday, March 23. Hank noted that, in its March 6 issue, the B.A.R. carried two articles (enclosed for those absent) related to ACT UP's history, anniversary and continuing mission. Extra copies of this issue of the B.A.R. had been brought to the meeting. Hank stressed the importance of people's financial and moral support for ACT UP Golden Gate, which is staffed by volunteer activists. He encouraged everyone to attend the anniversary bash.

At the close of his first public comment, Hank stated that he had some other announcements that he had hoped to make. He noted that there were no other members of the public who wished to give comment, and he asked for more time in this slot on the agenda (for which 20 minutes had been allotted). Chata reminded the group that the guidelines for public comment allow for just two minutes per person. The time on the agenda for public comment also includes HPPC members' responses to the comments made. The co-chairs agreed to move forward with other agenda items. Since a quorum had not yet been achieved, they decided to put the AIDS Office Update ahead of the Minutes Approval.

3. AIDS OFFICE UPDATE

Gene Copello explained that, in view of recent changes, both in the DPH co-chair position (Valerie's resignation and Gene's appointment in her place) and in the organization of the AIDS Office, he wanted to keep Council members informed of how the HPPC would continue to be supported by the AIDS Office. He distributed a packet with charts showing the current organization of the AIDS Office, and he spoke briefly about each page of the packet (enclosed for those absent):

p.1 *General organizational chart of the AIDS Office and its four branches.* The DPH, of which the AIDS Office is a part, is responsible to the Health Commission, which is appointed by the Mayor. The Health Services & Prevention Branch is the branch most closely involved with the HPPC. The Seroepidemiology and Surveillance Branch provides epidemiological data to the AIDS Office and to the HPPC process, for use in the Plan.

In one major change that has taken place in the organization of the AIDS Office, the Epidemiology and Evaluation Unit was removed from the Health Services and Prevention Branch and included in the Director's Branch instead. However, the Epidemiology and Evaluation Unit will continue to support the Health Services and Prevention Branch and the HPPC process, as well as the Mayor's Health Services Planning Council process. Primarily, Kristen Clements and Alice Gleghorn will continue to work on prevention issues from within the Epidemiology and Evaluation Unit.

p.2 *Breakdown of the Health Services and Prevention Branch,* chiefed by Gene Copello.

p.3 *Breakdown of the staff in each of the four units of the Health Services and Prevention Branch and their functional titles.*

p.4 *Further description of the Administration Unit.* The primary link between this unit and the HPPC is Grants Manager Tim Piland. The CDC Cooperative Agreement and the California State prevention contract that relates to the Council are both managed by him.

p.5 *Further description of the Planning & Policy Unit.* Previously, there were two separate units within the branch -- one for health services planning and one for prevention planning. In the last several months, those units were merged, in order to maximize expertise, develop more resources and address overlapping public policy issues. This combined unit is essentially responsible for the staffing of both this Council and the Mayor's Health Services Planning Council (or Ryan White CARE Council). The left side of the chart, under Unit Co-Chief Judith Klain, includes those staff who are most closely involved with the CARE Council; while the right side of the chart, under Unit Co-Chief Valerie Kegebein, includes those staff who are most closely involved with the HPPC (and who will

continue to provide support, in committee meetings and in full Council meetings). In addition, this unit anticipates public policy issues and analyzes legislation, so that the Health Services & Prevention Branch can proactively address them.

p.6 *Further description of the Program Development Unit,* which is responsible for negotiating contracts, monitoring contracts, providing technical assistance, and generally managing contracts -- both for health services and prevention -- that are funded by the AIDS Office. Within this unit, there are four individuals who primarily work with prevention contracts: Delia Garcia, Billy Pick, Lyn Fischer-Ponce, and Marshia Herring. Delia is one of the lead people linking the Planning and Policy Unit with the Program Development Unit.

p.7 *Further description of the Contracts Management Unit,* which takes responsibility for all of the technical work with contracts -- writing them and moving them through the system (purchasing, the Controller's Office, the Health Commission, technical reviews, etc.).

Discussion
Jimmie asked whether the Seroepidemiology and Surveillance Branch would now address HIV, STDs and TB simultaneously. Gene responded that, for now, the branch would only look at HIV/AIDS, but that the epidemiology for HIV/AIDS, STDs and TB would eventually be consolidated under this branch.

In relation to the organizational chart on p. 1 of the handout, Hank stated that the names of the people on the Health Commission should be shown. He added that there was currently a vacancy on the Health Commission, due to (former HPPC member) Commissioner Thomas Lee Eades' resignation, which had left the Health Commission without a gay man among its members.

Ana Claire asked whether the AIDS Office could be expected to keep its current organization for some time. Gene replied that, while the entire DPH is going through a process of reorganization, the current model of organization for the AIDS Office will probably remain intact for the next year. He added that, eventually, the Research Branch and Seroepidemiology and Surveillance Branch will be moving into "Community Health & Safety," which is also currently under the direction of Dr. Mitch Katz.

4. EXTENSION OF PUBLIC COMMENT
Following Gene's presentation, members briefly considered taking an early break to serve themselves food, which had arrived during the first few minutes of the meeting. The co-chairs noted that the meeting was significantly ahead of its agenda, and that members now had some extra time. Ellen made a motion to use this time to extend Hank Wilson's public comment, and to hear his remaining points. Her motion was seconded, and then received approval by consensus.

Popper Use and Promotion -- a Resurgence in the Gay Male Community
Former Council member and 1996 Epidemiology and Research Committee member Hank Wilson spoke about the use of nitrite inhalants, or poppers, among gay men. Speaking historically, he said that gay newspapers (in the early 1980's) used to run full-page ads for poppers. In 1983, activists on the Committee to Monitor Poppers (including founding member Hank Wilson) succeeded in convincing the S.F. Board of Supervisors to pass a point-of-sale warning on nitrite inhalants. Hank explained that the activists had intentionally chosen an educational strategy, rather than a

strategy of prohibition. With the community-based campaign launched against poppers, their use dropped greatly in the local gay community (in which usage had been extremely high).

In 1991, a prohibition ban on poppers was passed at the federal level. Now, Hank noted, popper sales and use seem to be coming back. He described an ad featured in Frontiers magazine. The ad for "Rush" urges its readers to order the product (poppers) today, or to assist with its distribution at local stores. It also lists the web site: WWW.beproud.com, which Hank found particularly disturbing in its intentional conflation of support for the product with support for the gay community. He expressed his concern that the younger generation of gay men, which wasn't aware of the gay community-based public health campaign launched against poppers in the 1980's, might get caught up in a resurgence of the popularity of this drug. Hank added that a growing body of research into the effects of poppers had produced significant evidence that they:

a.) are immunosuppressive (they weaken the body's natural defenses against disease); and
b.) encourage poor judgement and increase the likelihood of unsafe sex.

For both of these reasons, poppers appear to have had an aggravating influence on the HIV/AIDS epidemic in the gay male community, where their use has been heavily promoted and concentrated.

Hank told the Council that the response he had received when he called Frontiers was positive; the ad was promptly pulled from the magazine. However, the incident brought up the question of whose responsibility it is to make those calls when needed, to prevent the return of this problem to its former proportions in the community. Hank said that he felt that the responsibility must be shared by everyone in the community which includes HIV/AIDS activists, the DPH, researchers, and service providers. In closing, he stated that, while the prevention of popper use does not provide a solution to the epidemic, it does make up a small piece of the puzzle.

Discussion

John said that, since joining the Council at the end of last year, he had been waiting in meetings to hear something with real content. He expressed his gratitude and pleasure at having finally heard about something concrete that he could do to help prevent the spread of HIV in San Francisco.

Jelousy asked Hank if there was any way for the Council to obtain the research information available on poppers. Hank responded that he would be able to provide a packet of the existing research data on nitrite inhalants, but that he would need the AIDS Office to cover the printing costs, in order to allow for its distribution to the Council. Gene indicated that the AIDS Office could provide this assistance with the printing.

5. BREAK

6. ANNOUNCEMENTS

Steven Sams

- Steven made two announcements related to services listed and described in the 1997-98 San Francisco AIDS Foundation HIV Resource Guide. First, he told members that the Castro Lions Eye Care Program (p. 49), providing primary eye care services to people with HIV, has recently received a grant, and can now serve more clients. Secondly, he informed the group that the Godfather Service Fund (p. 141), which has been providing materials and support services to PWAs in hospitals, is now reviewing its mission -- to adapt to the change in hospital usage by PWAs. Now that hospital stays are down and other forms of care are being utilized more heavily, the Godfather Service Fund is looking for community input on ways to extend its mission to reach more PWAs.

Lyn Paleo

- Lyn announced that, once all existing copies of the 1997 San Francisco HIV Prevention Plan have been distributed, the Plan will be re-issued. Having noticed that some typographical errors remain in the current issue, Harder + Co. is currently accepting input on any such errors, which can then be corrected for the next issue of the Plan. Lyn requested that anyone who has found an error/errors in the Plan please call Ellen Irie at Harder + Co.: 522-5400, or fax a note to her at 522-5445, by March 25th. The assistance of planning participants in this final edit is greatly appreciated.

Ana Claire Meyer

- Ana Claire noted that, in the past, members had been directed to give any information on their absences or other attendance issues to the HPPC co-chairs. For this year, the procedure is being changed, so that Kevin Roe of the Process Evaluation Team will be taking responsibility for monitoring attendance. From this point onward, it is requested that members call Kevin about any HPPC meetings that they will have to miss or attend late. (Note: For committee absences or tardiness, committee members should still call their AIDS Office staff lead to give notice.)

Ronnie Ashley (Chata)

- Chata informed the Council of some personal circumstances that were making him feel vulnerable and tired. He explained that he wanted to let everyone know what was going on with him and to remind members to take care of themselves.

7. MINUTES FROM FEBRUARY 13

The co-chairs called for any corrections or additions to the minutes of February 13. The following corrections and clarifications were made:

1) Mary explained that Brian Dobrow's name should have appeared in the list of AIDS Office staff present at the meeting.
2) Mary noted that Stacy Vogan of the HIV/STD Prevention Training Center should have been listed as a guest, and not as a consultant to the HPPC process.
3) Jimmie asked for clarification on the time of the Roles and Responsibilities Task Force meeting scheduled for the next day. He was assured by other Task Force members that the time shown in the minutes (9:30am-1pm) was correct.
4) Jimmie asked what had happened in the one vote for which only 15 (rather than 16) members were counted as voting (p. 10 of the minutes). Ana Claire replied that someone must have either left the room without announcing it, or failed to raise their hand at all for the vote. The minutes of February 13 already record this inconsistency and its likely causes. Jimmie said that no further correction was needed.

With the first and second corrections mentioned above, the minutes of February 13 were approved by consensus.

8. COMMUNITY CO-CHAIR ELECTION

Gene reminded the group that, at the February 13 meeting, Ellen had been nominated for the position of community co-chair. He called for any additional nominations (none had been submitted to the AIDS Office or co-chairs since the previous meeting). Since no other nominations were made at this time, Gene announced the closing of the nominations process.

Ellen spoke briefly, as the nominee to the position of community co-chair. She said that she had communicated most of what she had wanted to communicate to the Council in her personal statement (mailed to all members), in which she discussed her intent to link prevention research with prevention service provision. She added that she wanted to do substantive work on the Council, and to have members use this space to talk about prevention in San Francisco, specifically -- in addition to what is mandated by the CDC (for general tasks and topics to be covered by the community planning process).

Gene informed the Council that it could elect Ellen by acclimation (the non-ballot process for election by consensus when there is only one nominee). He checked to see if there were any questions. Seeing none, he initiated the consensus process. Consensus was reached among those present (a quorum). Ellen Goldstein was elected as the new HPPC community co-chair.

9. EXPLORING THE PLAN

Ana Claire said that the small group discussions to take place at this point in the meeting were intended to prepare the members to do the work of the 1997 HPPC. She explained that members would be attending small groups focused on individual parts of the Plan, and she encouraged everyone to go to whichever discussion they felt would be most relevant to their particular committee (the committee they were planning to join).

Ana Claire reminded the group of the general committee directions and tasks for this year:

- *The Assessment Committee* will be drawing on the earlier work of the 1995 Priority-Setting Committee and the 1996 Resource Allocation and Resource Inventory Committee;
- *The Membership Committee* will continue in the vein of the 1996 Membership Committee;
- *The Strategic Evaluation Committee* will pursue the directions set by the 1996 Evaluation and TA Committee;
- *The Linkages Committee* will follow up on some of the 1996 Linkages Committee work, but with a new priority task for the definition of cultural competence; and
- *The Steering Committee*, composed of the co-chairs and the chairs of all of the individual committees, will provide coordination of committee activities; monitoring of progress on HPPC goals and objectives; development of new goals and objectives; support and recommendations to ensure the smooth operation of the Council; and development of a procedure for prevention provider requests for HPPC letters of support.

Lyn explained that the small group discussions on the Plan would be exploring the "conceptually denser" chapters, rather than going into all of them. She distributed a 46-page handout with summaries of the individual chapters, including HPPC-approved recommendations (enclosed for those absent). Ana Claire pointed out the facilitators/leads for each chapter discussion group:

- "Strategies and Interventions": Tracey Packer, AO staff lead to the 1995 committee;
- "Priority-Setting": Ana Claire Meyer, 1995 Priority-Setting Committee member and outgoing community co-chair;
- "Resource Allocation": Lyn Paleo, Harder + Co. technical support lead;
- "Epidemiology": Kristen Clements, AO staff lead to the 1996 committee; and
- "Strategic Evaluation/TA": Ellen Goldstein, 1996 Evaluation/TA Committee member, and incoming community co-chair.

Ana Claire explained that the members would now go to whichever small group chapter discussions interested them most. The Council divided itself into different parts of the room, which were identified with particular chapters of the Plan.

10. PROCESS EVALUATION REPORT

Following the small group discussions of the Plan, Kevin Roe got up to make a brief presentation for the Process Evaluation Team. Kevin distributed an evaluation handout (enclosed for those absent) summarizing the "Background Experiences" surveys (completed by 21 respondents), and he went over some of the results with the group present. The first four pages of the handout show the numbers of responses corresponding to particular levels of experience, in each of the different survey categories for experience. The next two pages of the handout break out the information by percentages of respondents claiming "not much, none, almost no experience" or "a lot to a great deal of experience" in particular categories. The final page lists additional areas of experience reported by the Council members in the survey.

Speaking for the Process Evaluation Team, Kevin recommended that Council members:

- Make as much use as possible of their collective strength in areas of experience such as "working with multicultural peers and colleagues," "providing health education/HIV prevention programs," and "working in a community-based organization."

- Support each other around the experience of losing a colleague or friend (reported by 71%), or losing an aquaintance (also reported by 71%), to AIDS. (Support those who have shared the experience, but also support those on the Council who may not yet have had that experience, and who will need to understand it.)

- Work toward filling more of the available research positions on the Council, and -- in the meantime -- at least get the information and clarification members need on research data.

- Work on mentoring, especially since someone on the Council made a point of showing that they have a great deal of experience with mentoring.

- Speak up in large groups, especially since 71% of the respondents reported a lot to a great deal of experience in that area.

- Try to identify those who have experience and strengths in the areas in which the Council as a whole is somewhat lacking (e.g., research, evaluation, proposal review, and Robert's Rules of Order), and enlist the help of those who have the kind of experience needed for particular committees.

11. HPPC COMMITTEES FOR 1997

"Self-Allocation" to Committees

Ana Claire explained this new approach of the Council to committee assignments. Rather than giving HPPC members forms for expressing their preferences, and then trying to put members on their first or second-choice committees -- the co-chairs decided to let members choose their own, and to negotiate with members where needed in order to improve the balance of experience and expertise on the committees. Pointing out the separate areas of the room designated for particular committees, Ana Claire told members that they would be able to go to the area corresponding to whichever committee they wanted to join. She noted that there are certain requirements for

representation, and that members would be expected to look at these issues themselves and to make some decisions about who should stay or leave, in order to improve the balance on the committee (and the co-chairs would visit the small groups and assist with these decisions, if necessary).

Requirements for Committee Representation and Support
Ana Claire gave members the following guidelines for forming balanced committees:

1) Each committee should ideally include a minimum of 5 and a maximum of 9 members.
2) Each committee should have a mixture of types of professional experience.
3) Each committee should have a mixture of new and continuing Council members.
4) Each committee should have some diversity in terms of age, ethnicity and gender.

Ana Claire added that each committee would be made up of **Council members** (voting members of the committee), **AIDS Office staff** (voting members of the committee *if* they attend regularly and do not outnumber the other members at a given committee meeting), **logistical and technical support staff** (*non-voting* consultants to the committee), and -- wherever possible -- **outside community members** (people not on the Council, but serving as voting members of the committee). At this point, she emphasized the need for community members on the committees, and asked Council members to have interested and appropriate aquaintances or colleagues of theirs call Gene, Chata or Ellen about joining a particular committee.

New Idea for Scheduling of Committee Meetings
Ana Claire informed the group that the co-chairs had come up with a new option for organizing the committee meetings. She said that regular Council meetings could still take place from 3-6pm (not 4-6pm, since it has become clear that the HPPC meeting agendas cannot be completed in two hours) on the second Thursday of each month. Then the third Thursday of each month would be used primarily for committee meetings (from 4-6pm), but with an hour at the beginning (from 3-4pm) for open, informal discussion of burning issues for the Council and its planning work.

Valerie spoke up to say that this scheduling arrangement should be discussed at this point as an idea and an option, rather than as something set in stone, because there were some issues that were not taken into consideration in the planning of it. For example, difficulties are likely to arise around the provision of logistical and technical support to the individual committees, if they all meet at the same time (since there is a limited number of support staff).

Jimmie asked whether it was practical to schedule only one meeting per month for each committee. Ana Claire responded that an occasional second business meeting for the full Council could be added on the fourth Thursday of the month, as needed. She also pointed out that committees needing additional time on their tasks could schedule separate meetings, to supplement the regular committee meeting time on the third Thursday of each month.

Liz spoke up to say that it seemed to her that, if everyone in a committee could agree on a better time to meet, the committee meeting should be scheduled for that time. She preferred this system of choosing a convenient time to the proposed system, which would require everyone to come together and meet during the day. As she pointed out, some of the committees regularly chose evening meeting times, in order to accommodate members' work schedules. Ana Claire responded that the new system had also been proposed to allow everyone on the Council to come together to discuss burning topics related to Council business, between the actual business meetings. Roberto stated that the latter idea made sense for the Council, but that he liked the previous system for

scheduling committee meetings. He felt that each committee should have the option available to meet whenever its members want to meet.

Ana Claire gave two major reasons for trying the system of holding committee meetings from 4-6pm on the third Thursday of every month:

1) The co-chairs wanted to create a way for the committees to meet more regularly.
2) Comments given in the evaluation forms suggested that some Council members prefer a more formal, predictable meeting time for their committees -- e.g., because of the difficulty of getting time off from work on short notice.

Roberto asked what would happen to the scheduling of the Steering Committee. Ana Claire replied that, since the chairs of all of the other committees sit together on the Steering Committee, it would have to have its meetings separately from the other committees, on its own schedule.

Barbara spoke in support of the idea. She said that it would be easier for her to make meetings at consistent times, which she could reserve as time away from her job. She added that, in her experience, even when committee members set their own meeting times, they often don't manage to attend. She suggested that attendance might actually be an independent problem.

Ana Claire said that the Council would probably give the newer system a trial run, starting in April. The meetings on the third Thursday would most likely be held at the AIDS Office.

Steven Sams asked how the Council attendance policies would apply to members on jury duty. Ana Claire responded that the general policy has been that a member who has missed two Council meetings receives a call to check up on reasons for absence and intentions for attending or resigning in the future. If that member has had jury duty, has been out of the country, or has had some other good excuse for missing the meetings, then the co-chairs have generally decided to allow them to continue serving on the Council. However, if the member then continues to miss meetings, the co-chairs begin to look at taking further steps to maintain the Council quorum.

Panel Presentation

Membership Committee

- Lyn presented for Christine Edwards, who had not been able to attend this meeting. She explained that this committee looks at the representation of people on the Council and at the process. She said that the committee's focus is on inclusion and members' needs, and that the specific tasks relate to membership retention, the Bylaws and Council procedures.

Strategic Evaluation Committee

- Ellen said that this committee would be looking closely at the three levels of evaluation outlined in the 1997 Plan:
  (1) Provider Level, which will focus on the Behavioral Risk Assessment in this year;
  (2) Intervention Effectiveness Level, which will investigate what prevention interventions seem to work in San Francisco with certain target populations, and will also involve a search and summary of information/articles on what has worked in other settings (the AIDS Office will take responsibility for identifying and securing funding for these projects, and DPH researchers or outside researchers/consultants will conduct them); and

(3) Population-Based Surveillance Level, which will involve research conducted by the DPH (or by researchers contracted by the DPH) and guided by the HPPC. This level of evaluation will examine what is happening (in terms of attitudinal change, risk change, and changes in infection rates) in the San Francisco community as a whole (beyond the population of prevention agency *clients*), and what overall impact has been had by local prevention interventions. The AIDS Office has already been awarded a CDC surveillance grant to begin this level of research.

Linkages Committee

- Chata explained that, in 1996, the Council had raised the question of how cultural competence fits into the RFPs and the new community standards for prevention services. This committee has been given the task of defining organizational cultural competence. With this aim, the committee will seek to summarize existing information on cultural competence and will receive input from culturally-specific agencies and other providers. The committee will then work on developing a tool to determine/measure cultural competence, and to be used for future prevention contracts. Chata identified this task as a huge undertaking, which would require a lot of information and a great deal of commitment. He said that the committee would have to strive to equally represent different populations. He noted that, should time permit, the committee would also undertake to (1) develop recommendations for the delivery of consistent prevention messages, and (2) guide the implementation of a system for referrals and other linkages (based in part on the recommendations from the 1996 Linkages Committee).

Assessment Committee

- Ana Claire explained that this committee will function not as a task force, but as an ongoing official committee of the HPPC. Its tasks will include a detailed examination of the Roles and Responsibilities document as it relates to the resource allocation process, a detailed review of how the 1996 resource allocation/RFP process went, the development of recommendations for how resource allocation might be done in the future, troubleshooting and brainstorming for future RFP/proposal review processes, a retrospective analysis of the 1995 model for priority-setting, a review of the current resource inventory (and identification of any remaining gaps in funding, in the context of the priorities established in the Plan), and an updating of the resource inventory.

Ana Claire noted that the Roles and Responsibilities Task Force was expected to disband in April, after completing the Roles and Responsibilities document and making recommendations for its implementation. She also reminded the group that the committee chairs and co-chairs would meet as the Steering Committee for the Council. The first committee meetings would be scheduled to take place at the March 27th HPPC meeting, for orientation and decisionmaking on committee composition (including chair selection).

Discussion of Panel Presentation

Chata asked about the AIDS Office staff leads to be assigned to the new committees, and Valerie responded that she would prefer that this announcement be made at the meeting on March 27. She assured the group that each committee would be supported by an AIDS Office staff person.

Vic asked whether his suggestion about proxies for PWAs on the Council had been registered, or whether he would need to write it out and submit it to the Membership Committee. Lyn responded

that his suggestion had already been recorded, and would be discussed at a future Membership Committee meeting (as an item for revision in the Bylaws).

Vic also asked whether the Strategic Evaluation Committee would be forming policy. Ellen responded that, last year, the committee had set policies for what evaluation activities would be mandated and for the units of service for evaluation in prevention contracts. She noted that, this year, the committee would be designing and choosing which evaluation directions and activities would be pursued. Ana Claire added that the HPPC also guides policy because the money for evaluation research comes from prevention planning funds. (Note: Kristen Clements asked that the minutes reflect the following correction: Some funding comes from the prevention planning funds, but it can also come from the CDC, NIDA, State and General funds, the Cooperative Agreement, and other grants. It is not all funding within the direct jurisdiction of the HPPC, although the guidance of the HPPC *will* determine the use of prevention planning funds for evaluation projects.)

In response to a question about the priority of cultural competence this year, Chata assured the group that cultural competence would be the primary focus for the 1997 Linkages Committee. Roberto asked Chata what he meant by the term "organizational cultural competence." Chata explained that the committee would be creating a tool for the AIDS Office and prevention providers to measure the cultural competence of an agency. The instrument would then be used in the RFP and contracts processes (e.g., as a tool for the RFP review teams).

Committee Selections -- Breaking into Small Groups for "Self-Allocation" to Committees
As members were directed to begin making their committee selections, Barbara spoke up to say that she felt somewhat troubled about the process, since not everyone on the Council was present (and thus, the actual balancing of committees could not be accomplished at this meeting).

Jimmie said that he thought the forming of committees was going to be difficult. He expressed his hope that there would be a priority given to the even distribution of new members across committees. He said that he thought a concerted effort to balance continuing with new members should be made, as part of the effort to provide mentorship, and in order to achieve a good mixture of experience and new perspectives. Ana Claire responded that every year starts with new members on each committee, and that their learning curve becomes part of the process.

Liz, noting that the Council was still ahead of its agenda, asked whether members might be allowed to take a few minutes to think about their preference of committees, before having to get up and join one. The co-chairs agreed to this short break for reflection before the small group orientations.

The following committee selections were made:

Membership Committee:
1) Jelousy Jiggetts
2) Ellen Goldstein

Linkages Committee:
1) Chata
2) Ahimsa Timoteo Bodhrán
3) Dawn Passar

Strategic Evaluation Committee:

1) Roberto Garcia
2) Henry Ocampo
3) Steven Sams
4) J. Colin Partridge
5) Bethsaida Ruiz
6) Liz Highleyman
7) John Newmeyer
8) Community member Mike Discepola

Assessment Committee:

1) Barbara Adler
2) Jimmie Naritomi
3) Gene Copello
4) Maria Rinaldi
5) Joel Reyna
6) Community member Ana Claire Meyer

12. FINAL ANNOUNCEMENTS/GIFT-GIVING

Ana Claire Meyer and Kevin Roe

- Ana Claire and Kevin explained that they had gone shopping for gifts to present to the Council, as a reward for its ongoing hard work. They then stood up and distributed gift packages from Sanrio, eagerly received by Council members and consultants alike.

Chata

- Chata announced that Mark Peppler, who had had to miss the beginning of the meeting but had arrived by this time, would be leaving the Council and San Francisco to take a new job in Austin. Mark said his goodbyes to the Council, and mentioned that he would be filling a seat on the CARE Council in Austin. Council members wished him well.

Kevin Roe

- Kevin briefly explained a new process evaluation activity in which members present at this meeting were asked to participate. On special forms distributed around the table, members were requested to write three words describing their feelings about this Council and the work ahead of them. Kevin asked people to complete the other evaluation forms as well.

13. CLOSURE

The co-chairs adjourned the meeting slightly before 6:00pm.

Enclosed with These Minutes (for those absent):

- "Ten Years on the Front Lines of an Epidemic" and "Join ACT UP's Big Birthday Bash Monday" -- two articles printed in the 3/6/97 issue of the Bay Area Reporter.
- Copy of ACT UP Golden Gate's flyer for the anniversary dinner and party
- AIDS Office organizational charts, with breakdowns by branch and by unit
- Summary of the chapters of the San Francisco HIV Prevention Plan
- Summary of "HPPC Member Background Experiences"
- 2/13/97 "Evaluation Results" and "Participant Dialogue" forms
- "1997 HPPC Members Biographical Sketches" (enclosed for HPPC members only)

(Note: Ahimsa called it to the notetaker's attention that a single flyer was brought to this meeting, regarding research and networking that a mixed-race woman was doing for a presentation in April on mixed-race/multi-racial people. The flyer was taken from the table early in the meeting, and so could not be copied for these minutes. If whoever brought the flyer could contact Mary Irvine at Polaris (777-3229) and/or Ahimsa, it would be greatly appreciated. Thank you.)

Next Meeting: Thursday, March 27, from 3-6pm at the First Unitarian Church (1187 Franklin)

- ⇒ Discussion will be held on the work done by the Roles and Responsibilities Task Force.
- ⇒ Committees will get started, holding their first meetings as 1997 committees, after the general Council business for this meeting is concluded.

Minutes Recorded by: Mary Irvine
Minutes Approved by: AO Co-Chair Gene Copello and Community Co-Chairs Ronnie Ashley, Ellen Goldstein (newly elected) and Ana Claire Meyer (outgoing).

HIV PREVENTION PLANNING COUNCIL MEETING

March 27, 1997
3:00 PM 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

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Meeting called by: **Co-Chairs:**
Ellen Goldstein
Gene Copello
Ronnie Ashley (Chata)

Please read: **Agenda and minutes of March 6, 1997**
***Please bring*:** **Entire Package**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Welcome/Introductions/Announcements	Chata	3:00 - 3:05 PM
2. Public Comment	Ellen Goldstein	3:05 - 3:25 PM
3. Minutes from March 6th	Chata	3:25 - 3:30 PM
4. Guest Presentation: AIDS Prevention PSA Series	David Weissman	3:30 - 3:50 PM
5. Guest Presentation: CDC Prevention Indicators Group	Deborah Rugg - CDC	3:50 - 4:20 PM
6. Process Evaluation Report	Kathleen Roe	4:20 - 4:35 PM
7. Break		4:35 - 4:45 PM
8. Roles & Responsibilities Task Force Update	Ana Claire Meyer	4:45 - 5:30 PM
9. HPPC Committees/Chair Selection	Ellen Goldstein	5:30 - 5:55 PM
10. Closure/Evaluation	Kathleen Roe	5:55 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC - Thursday, April 10, 1997, 3-6 PM, First Unitarian Church, 1187 Franklin Street (@ Geary).

DPH

HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for March 27, 1997

Please note in your calendar any of the following meeting times that apply to you:

Next Council Meeting: Thurs., April 10, 3-6pm at the Unitarian Church (1187 Franklin)
Next Steering Committee: Tues., April 15, 4-5pm at the AIDS Office (25 Van Ness)

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Members Present:
Barbara Adler
Ronnie Ashley
Isabel Auerbach
Ahimsa Timoteo Bodhrán
Ellen Goldstein
Vic Hernandez
Liz Highleyman
Jelousy Jiggetts
Sacul L'Adnbre
Ana Claire Meyer
Jimmie Naritomi
John Newmeyer
J. Colin Partridge
Joel Reyna
María Rinaldi
Bethsaida Ruiz

Guests:
Mike Discepola, AHP
Brenda Escobar, Iris Center
Janet Heitgerd, CDC
Cynthia Laird, B.A.R.
Debra Rugg, CDC
Stacy Vogan, HIV/STD PTC

Process Evaluation Team:
Pali Basi
Ruel Caneda
Cathleen Farrell
Cely Queiroz
Kevin Roe

Members Absent:
Hector Carrillo
Gene Copello
Roberto García
Kevin Gogin
Jennifer Lorvick
Askia Muhammad
Henry Ocampo
Dawn Passar
Steven Sams
Sandy Simms

Harder + Co./Polaris, Inc.:
Marty Forst, Polaris
Ellen Irie, Harder + Co.
Mary Irvine, Polaris
Steven LaFrance, Harder + Co.
Amalia Fernandez-Niewendorp, Polaris
Lyn Paleo, Harder + Co.

AIDS Office:
Kristen Clements
Brian Dobrow
Vince Guilin
Valerie Kegebein
Willi McFarland
Tracey Packer
Mike Pendo
Kim Shafer
Kurt Scheer

1. WELCOME & INTRODUCTIONS

Before people took their seats, Chata advised them to serve themselves refreshments. As an opening exercise, everyone present was asked to say their name and favorite food, in order around the room.

2. ATLANTA UPDATE

Ellen -- Information from Summit, Membership Perspectives/Composition, Involvement of S.F.
Ellen spoke about her experience at the recent Annual Co-Chairs Summit in Atlanta, which was also attended by some AIDS Office staff, Council members, and consultants from the San Francisco planning process. She passed around a stack of brochures and literature she had picked

up at the conference, and said that she had more that she could bring to future meetings. She said that, while at the Summit, she had heard some interesting perspectives on membership recruitment and retention. Most other Councils, she explained, have more of a consumer perspective (than the San Francisco HPPC) and less representation of CBO staff among their members. Ellen noted that she had presented twice at the Summit, and had also been able to attend a women's affinity group, with information on trends in HIV/AIDS infections among women of color. In closing, she said that she would like to make people more aware of such conference opportunities in advance, in order to gain greater attendance from San Francisco.

Ana Claire -- Conflict Resolution in Other Planning Councils
Ana Claire said that this had been her second year of attending the Co-Chairs Summit in Atlanta, and that she had served on the Steering Committee for the event this time. She was assigned to give four workshops, and only managed to go to one other: "Beyond Concurrence" (referring to the collaborative relationship between DPH and community co-chairs). The workshop discussed approaches to conflict resolution. Ana Claire had observed at this workshop that other planning groups were having similar problems to those encountered by the San Francisco HPPC, and that the DPH and community co-chairs expressed similar concerns on both sides -- having to do largely with a lack of respect and/or a lack of trust exhibited by one type of co-chair toward the other.

Valerie -- Presentation Topics
Valerie reported that she had presented in two workshops: one (with Lyn Paleo) on prioritizing strategies and interventions, and one on using qualitative data on a population.

Lyn -- Newer Information on the Relationship Between STDs and HIV Transmission
Lyn informed the group that she had been to a workshop on STDs and HIV prevention, in which she heard some new information -- which the CDC is hoping to get out to the public -- regarding the greater likelihood that people with STDs (as compared to people without them) will sexually transmit or become infected with HIV. She explained that the findings showed that, in people with STDs, T-cells tend to cluster where they can be easily tackled by the virus, and -- for those who are also HIV-positive -- virus sheds more, putting sexual partners at increased risk for infection.

Joel -- Knowledge/Perspective Gained at the Conference
Joel reported that he had gleaned a great deal from the Summit, including:

1) some perspective on the history and future of planning;
2) the understanding that San Francisco has made some important progress in community planning; and
3) the realization that the overall representation of people of color at the Summit was low (with Latinos being especially underrepresented).

Chata -- Concerns re: Prevention and Culturally-Specific Communities, Low HIV-Pos. Presence
Chata explained that this had been his first time attending the Summit as a co-chair. He said that he was interested to find out what everyone else was doing, in comparison with the San Francisco planning process. He also distributed a handout (enclosed for those absent) with a more detailed report of the thoughts and recommendations arising from his experience at the conference (particularly regarding the need to address cultural difference and cultural/linguistic barriers to HIV-related service usage). Chata said that he had attended all of the Native American, African American, Latino, and Asian/Pacific Islander workshops held at the Summit. He witnessed people's difficulties (due to a lack of information on specific cultural populations) with priority-

setting and with epidemiological data. Chata also said that the conference had called his attention to the lack of services for people in rural communities.

Chata added that he was concerned about the apparently very low attendance of the conference by people with HIV. He noted that, in a crowd of several hundred people, only about 10 people had risen when a speaker asked everyone with HIV to stand.

In closing, he expressed his overall sense that a lot was being accomplished, with a great deal of innovation -- but that there was always room for improvement in this community planning process.

Discussion

Primary and Secondary Prevention, and the Scope of Community Prevention Planning

Ellen told the group that she had also attended a panel on primary and secondary prevention, and had learned that both fall within the purview of the HPPC. She noted that primary and secondary prevention for people with HIV, as well as primary prevention for those who are HIV-negative, should be included in this community planning process. She called the panel "eye-opening." Liz asked whether post-exposure prophylaxis (treating a person immediately following their possible exposure to HIV, in order to minimize any virus present) would fall under the category of prevention as well. Ellen responded in the affirmative. By the CDC definitions, primary prevention refers to interventions designed to stop transmission, for a target audience that may be either HIV-negative or HIV-positive; and secondary prevention refers to interventions designed to keep HIV-positive people from progressing into disease.

Meeting on Post-Exposure Prophylaxis

Valerie announced that Dr. Mitch Katz would be holding a meeting on Friday (March 28) at the AIDS Office, for prevention providers to talk about post-exposure prophylaxis and about what the DPH will do to educate providers on the issue. She added that a discussion of this topic would be put on the HPPC agenda for April 10.

Low Visibility of People with HIV at Atlanta Summit

Kevin, who had also attended the conference, expressed his pleasure at having seen that the San Francisco HPPC is not at all alone in struggling with the issues of community planning. He echoed Chata's point about the instance in which HIV-positive attendees at the conference were asked to stand, and just a handful or two of the several hundred people present did. He wondered whether there was some kind of homophobia or HIV-phobia operating at the conference (and keeping people from disclosing their positive HIV status), or whether there was simply an enormous underrepresentation of people with HIV.

3. ANNOUNCEMENTS

Lyn -- Corrections to Plan

- Lyn announced that members should hurry and send in any last-minute corrections they might have on typographical errors in the Plan. Please fax (522-5445) or phone (522-5400) in these editing suggestions to Ellen Irie of Harder + Co., if you haven't already.

Ellen -- HPPC Nominations, New UCSF Web Site, Tickets Donated by Black Rep. Theatre

- Regarding nominations for new members, Ellen stated that the co-chairs would be particularly interested in getting people with HIV, people of color, and non-service providers to join the HPPC. She asked that current members either post an announcement

about this opportunity to serve on the Council (where service clients could see it, for example) or mention the open positions to people who do something other than HIV prevention for their primary occupation. April 16th is the deadline for nominations.

- Ellen also informed the group that UCSF had just opened a new World Wide Web site on the internet. The site (http://hivinsite.ucsf.edu) includes information on care, treatment, prevention, and epidemiological data -- and it has links to specific information on a variety of sites. Ellen described this new site as a great resource, and noted that it will not replace the CAPS web page. She distributed a card with all relevant information on accessing HIV InSite (card information enclosed for those absent).

- Ellen had 23 tickets available at no cost for "Bubbling Brown Sugar," for Thursday and Friday night. She offered them to those interested at the meeting, and explained that the Black Repertory Theatre had contacted her and given her these tickets to show support for the work of the HPPC. Members expressed gratitude and interest.

Chata -- Excused Absences, Presentation of Plan to Health Commission, Coburn Bill

- Chata announced that Gene Copello was out today, Henry Ocampo was sick, and Steven Sams was on jury duty. To his knowledge, others absent had not yet called to notify the co-chairs. (Note: Christine Edwards has resigned from the Council. Due to a recent job change, she can no longer represent the Forensic AIDS Project.)

- Chata announced that on April 8th the co-chairs would present on the 1997 San Francisco HIV Prevention Plan, to the Health Commission. He said that the meeting would begin at 3pm, on the 3rd floor of 101 Grove St.

- Chata told the Council that the co-chairs, on behalf of the Council, were working on a draft of a response to the Coburn bill. The bill, proposed by conservative Oklahoma Representative Tom Coburn as the "HIV Prevention Act of 1997," would create new provisions for mandatory HIV testing and reporting, as well as for compulsory notification of sex partners. Brian Dobrow added that the author of the bill calls AIDS "obsolete." Because of the problems that this bill could create for, among other things, the accessing of and provision of HIV prevention and care services -- the co-chairs wanted to ensure that this prevention planning body issued a response.

Brian -- Information Requested (and Now Available) on the Recent Prevention RFP Process

- Brian noted that a document (enclosed for those absent) related to the RFP process had been left out on the table for members to take. He said that the document describes the AIDS Office prevention RFP process used last year, which Council members had asked to have detailed for their information.

4. PUBLIC COMMENT

No public comments were offered at this meeting.

5. MINUTES FROM MARCH 6TH

Without any corrections or additions, the minutes of 3/6/97 were approved by HPPC consensus.

6. GUEST PRESENTATION: CDC PREVENTION INDICATORS GROUP

Introduction -- Strategic Evaluation Planning, and Population-Based Surveillance Research
Kristen Clements gave a brief introduction to the presentation by Drs. Debra Rugg and Janet Heitgerd of the CDC. She explained that the Council (and its Evaluation and TA Committee, specifically) had looked last year at three levels of evaluation -- defined as the "provider level," "intervention research level," and "population-based prevention surveillance level." For the third level (population-based prevention surveillance), the Council agreed that existing and new sources of data should be used to evaluate the overall impact of prevention services citywide (not limited to the effect on clients of prevention services, but including all of San Francisco). Kristen explained that, at the same time, the CDC had been developing its own strategic evaluation plan, which had ended up resembling the HPPC strategic evaluation plan fairly closely. She said that a number of RFPs had come out for the third (surveillance) level of evaluation. The AIDS Office wrote a proposal, which -- with the support of the HPPC -- won funding for prevention indicators research. The three health jurisdictions awarded under the CDC prevention indicators research RFP include San Francisco City and County, Texas State, and Minnesota State. In closing, Kristen noted that the prevention indicators work would be examined by the Strategic Evaluation Committee this year. The AIDS Office will gain input from the committee on how best to use data sources.

Debra Rugg -- The CDC Approach to Prevention Evaluation
Debra expressed her pleasure at being back in San Francisco. She said that she had been at the CDC for 10 years, and she described the new evaluation effort as one of the most comprehensive and well-thought-out efforts made in this area. She pointed out that the HPPC and CDC (as well as other different planning bodies, organizations, and researchers) sometimes use different evaluation terms to mean the same thing. For example, the CDC generally talks about "process evaluation" to refer to provider-conducted evaluation. Debra described the difficulties of prevention evaluation as stemming from the great complexity of HIV prevention as a field. She explained that the CDC had decided to begin by laying out a complete plan for evaluation.

Debra introduced her colleague, Dr. Janet Heitgerd, who is also working on the prevention indicators process. She then projected an overhead with the name of the center where they work at the CDC -- the National Center for HIV, STD & TB Prevention. After distributing a packet of summary information on CDC HIV prevention program evaluation (enclosed for those absent), Debra proceeded with her presentation, using an overhead projector. (Note: The information from the overheads can be found in a separate packet, copied with these minutes for all HPPC members. Please refer to this packet for an outline of her presentation.) Debra explained in closing that, for impact evaluation, the CDC plans to pilot test its prevention indicators, to learn what is most useful to communities and to prevention planning and programming. She explained that the CDC currently has a draft list of about 100 possible prevention indicators, and that this list will have to be narrowed and refined to produce about two dozen final prevention indicators.

Janet Heitgerd -- The CDC HIV Prevention Indicators Project
Janet described presenting to the Council as a learning experience for her, since she has not previously had contact with the community prevention planning efforts. She presented an overview of the CDC HIV Prevention Indicators Project, projecting as overheads the materials which she had distributed to the group present at this meeting (packet enclosed for those absent). She explained that, to complete this project, the CDC had set out to collaborate with state and local health departments and evaluation experts. The project is using existing data, and does not itself support any new surveys or surveillance systems.

In December, the CDC held a meeting for representatives from various different groups to talk about the HIV Prevention Indicators Project. Four workgroups, corresponding to the four CDC-defined sub-epidemics (MSMs, IDUs, high-risk heterosexuals, and child-bearing women), met and came up with a total of over 100 draft prevention indicators (including biological, behavioral, knowledge-based, and social indicators). Janet pointed out that the MSM workgroup alone had suggested over 80 indicators. At a meeting in June, the list will be reduced and refined -- according to relevance to HIV, measurability, reliability, feasibility, cost, acceptability, usefulness, etc. of the draft indicators. Pilot testing of the chosen indicators will take place following this June meeting. Janet summarized that the CDC hoped the project would inform prevention professionals about where their communities are in relation to where they want them to be, and about which program activities require further evaluation.

Discussion

The Wait for Comprehensive Prevention Evaluation

John said that he found it astonishing that this evaluation research effort had not been made until now. He described the leadership at the CDC level as competent and appropriate now, as compared with 10 years ago. Debra explained that evaluation always seems to happen after the fact, and that it especially takes time to begin to see impact. She stated that evaluators generally look for immediate outcomes, before beginning to assess impact. However, she acknowledged that this project could probably have begun some years earlier (though fewer than 10 years ago); and she said that evaluators at all levels experience the kind of frustration that John expressed over the delays common to evaluation.

Definition of "High-Risk Youth" for CDC Prevention Evaluation Purposes

Jimmie asked about how "high-risk youth" would be defined, for the purposes of CDC studies. He explained that the HPPC had decided upon a model of behavioral risk groups, with factors such as age figuring in as covariates. Debra responded that the CDC recognizes "high-risk youth" as youth in particular high-risk situations; the CDC commonly refers to a list of 10 such situations. She went on to say that each evaluation study has a different purpose, and that it is harder to get at specific population characteristics when dealing with impact indicators. She suggested that it might be easier to look at in-school youth, for example (the Youth Risk Behavior surveillance system is targeting in-school kids in more than 30 states in the United States) -- but that the data would not be able to provide a great deal of detail. Janet added that the workgroups at the December meeting to draft prevention indicators had recognized the issue of age, but had also anticipated difficulties for measurement. They did attach age ranges for some of the indicators.

Surveillance on School Sites (Asking About Sexual Behaviors of In-School Youth)

Jimmie mentioned that there has been a problem with schools not allowing behavioral studies on school sites. Debra responded that the YRB system is on-site at schools. Ana Claire pointed out that some states don't allow the YRB to include questions about sexual behaviors. Mike Pendo stated that the YRB is conducted in San Francisco schools, and that those schools do permit questions about sexual behaviors.

Distribution of List of Draft Prevention Indicators from the CDC Process

Vic asked whether the list of all draft prevention indicators might be made available to Council members. Janet offered to give the list to those interested, but cautioned that it should be seen as only a draft. In view of other members' expressed interest in seeing the list, it was decided that the AIDS Office would send the draft list to Mary, for copying and distribution to the full Council.

(See attachment to these minutes, for all members.) Debra noted that there would soon be more refined drafts of this list. Vic explained that he would appreciate the opportunity to look at the earlier draft, in order to keep track of what does or doesn't get incorporated into later drafts. Debra recognized his point, and noted that the Council might also want to see future drafts. She added that the process for choosing prevention indicators is very involved, using both a delphi process and programmatic feedback, partly because the researchers are trying to select indicators that will last for awhile in their usefulness.

Indicators for Condom Use, and Surveillance of Psycho-Social Factors
Barbara asked about condom use and whether this CDC prevention evaluation project would include any surveillance of psycho-social factors. Debra replied that some measures of condom use are already available, but that there are few behavioral and no psycho-social measures available. However, the project has broken out current core indicators and "future need" indicators, which the CDC will attempt to integrate into the surveillance system. Psycho-social factors will figure heavily into the category of future need indicators.

Information-Sharing, and the Place for HPPC Input
Ellen thanked Dr. Debra Rugg and Dr. Janet Heitgerd for coming to present at this meeting, and expressed her sense of the value of this kind of activity, for keeping the HPPC membership informed of issues and projects with some bearing on the future of prevention planning. She also asked the presenters whether there was any way in which the HPPC might help them in their work. Debra replied that it would be interesting to her and to others working on the HIV Prevention Indicators Project to hear how the indicators might become useful to the members of the HPPC. María stated that information on the indicators would have been much more useful to prevention providers six months ago, when it might have informed their proposals responding to the AIDS Office prevention RFPs. Debra expressed the intention of CDC evaluation project staff to share such information early, in order to allow for early adoption and feedback, which could shape the CDC process. She added that the efforts of the CDC in this direction partially explain why San Francisco fared so well in the competitive grant process for prevention impact evaluation research.

Regarding the communication of HPPC input back to the CDC evaluation project staff, Kristen noted that Willi McFarland and Kim Shafer of the AIDS Office are the primary investigators in the San Francisco surveillance research site. In addition, the AIDS Office has Kurt Scheer providing data management for the project, and Vince Guilin fulfilling numerous other project responsibilities. Kristen told the group present that Willi would bring information from the AIDS Office prevention indicators project team to the Strategic Evaluation Committee of the HPPC, which would give feedback for Willi to relay to the CDC.

Next CDC Prevention Indicators Project Meeting
As a final announcement, Debra Rugg let the Council know that the next big meeting of the CDC Prevention Indicators Project group was scheduled to take place on June 12th and 13th.

7. PROCESS EVALUATION REPORT
Handouts
Kevin Roe presented for the HPPC Process Evaluation Team, and he explained that Dr. Kathleen Roe was out of state and could not attend this meeting. He itemized and briefly explained the evaluation handouts distributed at this meeting:

- "Evaluation Results" (which should be dated for the HPPC meeting date -- 3/06/97);
- "Participant Dialogue: 3/06/97";

- "Community Outreach" form (explained on page 8 of the HPPC minutes of 2/13/97); and
- "Three Words" summary of the descriptions given by members at the last meeting, of their feelings about the HPPC and the work ahead of them.

Process Evaluation on the Committee Level
Kevin noted that members would be breaking into committees later in this meeting, and he introduced the evaluation team consultants for each committee (listed at the end of these minutes). He told the Council that the evaluators were planning to be somewhat more vocal on their committees this year, whereas last year they served mostly as silent observers who made occasional reports. Kevin said that the evaluation consultants would be looking out to ensure that the committees meet the requirements for parity, inclusion, and representation (PIR), and that they would give committee members feedback from time to time on their group process.

Planned Process Evaluation Activities for 1997
Kevin also informed the Council that this year's Process Evaluation Team would be conducting phone interviews (with each evaluation consultant interviewing the members of his/her own committee), and exit interviews (to take suggestions from departing members for the future of the Council). He added that, if resources were still available for further process evaluation activities, the team would put together focus groups (e.g., for HIV-positive Council members to discuss and make recommendations on issues such as Council participation and barriers to it). Kevin asked members with any suggestions for possible focus groups to write down their ideas in the dialogue box reserved for comments to the Process Evaluation Team.

Presentation -- Interests and Concerns of the Council
Next, Kevin proceeded to give a presentation with overheads, summarizing interests and concerns expressed by members of the Council. (Please see the copies of these overheads, enclosed for all members.) Regarding the concerns expressed about barriers for reading and understanding English, Kevin asked that members with any suggestions on this issue please write their ideas in the dialogue boxes -- or speak with an evaluation consultant about how to make materials and/or discussions more accessible and engaging. Regarding committee participation of community members, Kevin stated that the Process Evaluation Team would be exploring ways to bring community members onto committees and to get them involved in the prevention planning work. Regarding the roles and responsibilities of different parties in the planning process, Kevin noted that this has been an ongoing concern of the Council since late last year, and that the Roles and Responsibilities Task Force is still working on a draft document setting the guidelines for planning participation and purview.

"Three Words" Review
After giving his presentation, Kevin asked members to read aloud the comments submitted in response to the "Three Words" exercise at the last meeting. Those present read out the words in groups of three. Kevin summarized that many members seemed to feel some combination of hope, excitement, and/or challenge. He added that, while there was also some skepticism in the mix, members were generally expressing a wish to move forward.

Response of Planning Participants in Other Jurisdictions to the HPPC Process Evaluation
Debra Rugg commented that the evaluation activities of the San Francisco HPPC Process Evaluation Team, as presented at the Annual Co-Chairs Summit and other forums, were taking the nation by storm. Other planning councils, she explained, have been struggling with process issues and have expressed their admiration and gratitude for what they have seen of the approach taken

by Dr. Kathleen Roe and her team. This is another area in which the San Francisco planning process seems to be serving as a helpful model for other jurisdictions.

8. PARTING REMARKS -- OUTGOING COMMUNITY CO-CHAIR ANA CLAIRE MEYER

Thoughts and Feelings About Leaving the HPPC

Ana Claire explained that she had drafted a speech for her departure, but had decided not to use it, and to speak as she was feeling at the moment instead. She talked about how the past year had been difficult for her, in terms of the Council and in terms of the general experience of beginning to witness deaths among the people she knows from having been in the field of HIV/AIDS for a few years. She expressed her sense that the HPPC process had not gone quite as expected (particularly around the Delta Study of women who have sex with MSM&Fs, and around resource allocation), and that it had been an especially tough planning year for women of color (and services to them). She added that, at a couple of points in the last year, she had wanted to quit, but had been convinced by others involved in this process to remain in her role on the Council.

Ana Claire told the Council that she was glad that she had stayed with it, but that she found it difficult to be leaving at this time, when people seem finally to be pulling themselves out of the bitterness and disappointment that the group experienced last year. She expressed her pleasure at seeing the shift in the morale of the Council, and her wish to have been able to see more.

Experience of the Atlanta Co-Chairs Summit, Co-Chair Suggestions on Working Together

Speaking briefly about the Co-Chairs Summit, she said that it had been good to learn from other planning groups that were currently dealing with, or were successfully resolving (in the case of the California and Arizona state planning groups), the same kinds of issues encountered by the San Francisco HPPC. She reported that the Arizona council's DPH co-chair had told her that the representatives of the departments of public health simply need to let go, and that the process moves much more smoothly when they do. She also reported that a California planning group co-chair had stated that communities need to let go of their mistrust of all government agencies and representatives, in order to work together on the planning process. Finally, she described the HPPC work as a national model and standard for community planning, and expressed her satisfaction at seeing how much people at the conference wanted to hear from San Francisco.

Thanks to the People Involved with the HPPC Process

In closing, Ana Claire thanked specific people and groups working on the Council, and then gave a general thanks to all those involved with the process. She wished luck to Ellen and Gene as new co-chairs.

Good-Byes to Ana Claire

María, Barbara, John, Jimmie, Sacul, and Chata all responded to Ana Claire's statements. They expressed support, pride, gratitude, and admiration for her accomplishments; and they also spoke about their hopes for her future work in this field.

9. BREAK

10. HPPC COMMITTEES: ORIENTATION/COMPOSITION/CHAIR SELECTION

Ellen's Introduction to the Small Group Meetings

Ellen explained that Council members would break into committee groupings to become oriented to the work of their committees and to discuss tasks, timelines, roles, responsibilities, and membership composition. She asked members to pay special attention (1) to whether their committees met the criteria posted at the last meeting and in the minutes of 3/6/97, and (2) to what would be needed to ensure sufficient committee participation of community members. Regarding the recruitment process, she stated that members should send in their completed nominations forms to Brian Dobrow at the AIDS Office, so that he could mail nominees an official welcoming letter with information on joining the planning process. Aside from the orientation items, Ellen pointed out that it would be important for committee members to address (1) what information they would need to get started on their tasks, and (2) the selection of a committee chair. Finally, Ellen announced the upcoming meeting times (see box at bottom of these minutes), before members broke out into committee groupings.

Committee Materials

In committees, packets were distributed to all present. A packet with general information applicable to all committees (enclosed for those absent) was distributed to everyone, and the consultants for individual committees also distributed committee-specific packets to their members. (Note: Absent committee members should request a copy of their particular committee packet from the logistical or technical consultant assigned to their committee).

Current Composition of Committees (still open to additions)

At this meeting, committees appeared to include the following members, AIDS Office staff, and consultants:

LINKAGES COMMITTEE

AIDS Office Staff Lead:	Tracey Packer
Technical Consultant:	Ellen Irie, Harder + Co.
Logistical Consultant:	Mary Irvine, Polaris, Inc.
Process Evaluator:	Ruel Caneda
Council Members:	Ronnie Ashley (Chata)
	Ahimsa Timoteo Bodhrán
	Vic Hernandez
	Sacul L'Adnbre -- **elected as chair, 3/27/97**
	Dawn Passar (not present on this date, but signed up for this committee)

Decisions and Issues from this First Meeting:

- ⇒ The Linkages Committee members were asked to think about what types of community members they would want to have join them, as well as what they would need from their consultants and their AIDS Office staff lead.
- ⇒ While Sacul was elected as the official chair of the committee, Ahimsa expressed interest in supporting Sacul in her role and being mentored by her.
- ⇒ Members were asked to call Tracey Packer (554-9992) if they have to miss or come late to a meeting at the AIDS Office.

ASSESSMENT COMMITTEE

AIDS Office Staff Lead: Valerie Kegebein
Technical Consultant: Lyn Paleo, Harder + Co.
Logistical Consultant: Amalia Fernandez-Niewendorp, Polaris, Inc.
Process Evaluator: Pali Basi
Council Members: Barbara Adler
Gene Copello (not present on this date, but signed up for this committee)
Jimmie Naritomi
Joel Reyna
María Rinaldi -- **elected as chair, 3/27/97**
Community Member: Ana Claire Meyer, outgoing HPPC community co-chair

Decisions and Issues from this First Meeting:

- ⇒ María Rinaldi was elected as the committee chair, but expressed some concern about the time scheduled for the HPPC open discussion on the third Thursday of each month; she may not be able to arrive in time for the 3-4pm HPPC meeting on the third Thursday.
- ⇒ Members voiced concern about the current lack of African-American representation on this committee.
- ⇒ Members also expressed a desire to bring in community members with research and/or evaluation experience and expertise.
- ⇒ The group was informed that a room had already been reserved for its meetings at the AIDS Office, for the third Thursday of every month.

STRATEGIC EVALUATION COMMITTEE

AIDS Office Staff Lead: Mike Pendo *(and/or possibly Kristen Clements?)*
Technical Consultant: Marty Forst, Polaris, Inc.
Process Evaluator: Cathleen Farrell
Council Members: Roberto García (not present on this date, but signed up for this committee)
Liz Highleyman
John Newmeyer
Henry Ocampo (not present on this date, but signed up for this committee)
J. Colin Partridge
Bethsaida Ruiz
Community Members: Michael Discepola, AIDS Health Project
Stacey Vogan, HIV/STD Prevention Training Center

Decisions and Issues from this First Meeting:

- ⇒ The committee was unable to pick a chair at this meeting. Nobody volunteered to serve, and the members preferred to wait to elect a chair, until Roberto and Henry were present.
- ⇒ Members expressed concern that there were not yet enough people of color on the committee.

MEMBERSHIP COMMITTEE

AIDS Office Staff Lead: Brian Dobrow
Technical Consultant: Steven LaFrance, Harder + Co.
Process Evaluator: Cely Quieroz
Council Members: Ellen Goldstein
Jelousy Jiggetts -- **elected as interim chair, 3/27/97**

Decisions and Issues from this First Meeting:

⇒ This committee recognized its serious need for more members -- from both the Council and the community.

⇒ Jelousy Jiggetts agreed to serve as an interim committee chair, at least until the time that more members can join and make a group decision about their leadership.

12. CLOSURE/FINAL ANNOUNCEMENTS

Chata welcomed the group back into the circle for the following two announcements:

New Polaris, Inc. Consultant

- Amalia Fernandez-Niewendorp, who sat at the table with members at this meeting, is the new Polaris, Inc. logistical consultant being added to the HPPC support staff. She will be working alongside Mary Irvine until the end of June, at which point she will take over the primary responsibility for all logistical support to the Council. At this meeting, she sat in on the Assessment Committee, for which she will probably continue to provide logistics.

Chair Election Results

- The elected committee chairs -- María Rinaldi, Jelousy Jiggetts, and Sacul L'Adnbre -- were introduced and welcomed by the Council into their new roles.

Enclosed with These Minutes (for all members):

- Packet of overheads from Dr. Debra Ruggs' presention on HIV prevention evaluation
- List of *draft* HIV prevention indicators, from the December meeting held by the CDC
- Packet of overheads from Kevin Roe's presentation for the Process Evaluation Team

Enclosed with These Minutes (for those absent):

- Letter from Community Co-Chair Chata regarding the 1997 Co-Chairs Prevention Summit
- Card (or a copy of it) with information regarding the new UCSF Web site, "HIV InSite"
- Packet of additional notes corresponding to Debra Rugg's presentation
- Overheads from Dr. Janet Heitgerd's presentation on the Prevention Indicators Project
- "Evaluation Results" and "Participant Dialogue" forms from the 3/6/97 HPPC meeting
- "Three Words" results page
- AIDS Office document: "Request for Proposals (RFP) Process (Prevention)"
- Flyer for the C.H.A.M.P. "Stitch and Bitch" sewing circle
- "First Committee Meeting Agenda" with attachments relevant to all HPPC committees

Minutes Recorded by: Mary Irvine
Minutes Approved by: Community Co-Chairs Ellen Goldstein and Chata (Ronnie Ashley)

HIV PREVENTION PLANNING COUNCIL MEETING

April 10, 1997
3:00 PM 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Gene Copello
Ellen Goldstein
Ronnie Ashley (Chata)

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Please read: **Agenda and minutes of March 27, 1997**
Please bring: **Minutes of March 27 and Plan Summary**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Food/Welcome/Introductions/Announcements	Ellen Goldstein	3:00 - 3:15 PM
2. Public Comment	Ellen Goldstein	3:15 - 3:35 PM
3. Minutes from March 27th	Ellen Goldstein	3:35 - 3:40 PM
4. CDC Supplemental Discussion	Ellen Goldstein	3:40 - 4:40 PM
5. Break		4:40 - 4:50 PM
6. Guest Presentation: Transgender Study Update	Kristen Clements	4:50 - 5:15 PM
7. Process Evaluation Report	Kathleen Roe	5:15 - 5:25 PM
8. Post Exposure Prophylaxis	Mitch Katz	5:25 - 5:55 PM
9. Closure/Evaluation	Kathleen Roe	5:55 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC & Committee Meetings - Thursday, April 17, 1997, 3-6 PM, AIDS Office (3rd Floor) 25 Van Ness Ave.

(HPPC will meet from 3:00 to 4:00 PM and Committees will meet from 4:00 to 6:00 PM)

DPH

HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for April 10, 1997

Please note in your calendar any of the following meeting times that apply to you:

Council Meetings:	♦ Thurs., May 8, 3-6pm at 1187 Franklin St. (at Geary Blvd.); and ♦ Thurs., May 15, 3-4pm at the AIDS Office (25 Van Ness Ave.)
Committees:	♦ Thurs., May 15, 4-6pm at the AIDS Office (25 Van Ness Ave.)

Members Present:
Barbara Adler
Ronnie Ashley (Chata)
Ahimsa Timoteo Bodhrán
Gene Copello
Ellen Goldstein
Vic Hernandez
Liz Highleyman
Jelousy Jiggetts
Sacul L'Adnbre
Askia Muhammad
Jimmie Naritomi
J. Colin Partridge
Dawn Passar
Joel Reyna
María Rinaldi
Steven Sams

Members Absent:
Isabel Auerbach
Hector Carrillo
Roberto Garcia
Kevin Gogin
Jennifer Lorvick
John Newmeyer
Henry Ocampo
Bethsaida Ruiz
Sandy Simms

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AIDS Office Staff:
Kristen Clements
Brian Dobrow
Valerie Kegebein
Tracey Packer (with her son, Jack)
Mike Pendo

Guests:
Nikki Calma, API Wellness Ctr.
Tamara Ching, SE Asian AIDS Prev. Project
Mike Discepola, AHP / Evaluation Committee
Anita Hernandez, Iris Center
Cynthia Laird, B.A.R.
Nashanta Stanley, TG Study CAB member
Doan Thai, API Wellness Ctr.
Stacy Vogan, STD/HIV PTC
Kiki Whitlock, API Wellness Ctr.
Craig Yee, API Wellness Ctr.

Harder + Co./Polaris, Inc. Consultants:
Ellen Irie, Harder + Co.
Mary Irvine, Polaris
Amalia Fernandez-Niewendorp, Harder + Co.

HPPC Process Evaluation Team:
Pali Basi
Ruel Caneda
Cathleen Farrell
Cely Queiroz
Kathleen Roe (and her son, Cameron)
Kevin Roe

1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Ellen convened the meeting shortly after 3:00pm. She invited members present to take food and drinks from the table. Then she began the introductions with an exercise in which everyone was asked to say their name and something good that had happened to them that week.

Announcements:

Valerie -- Notification of Member's Absence

- Valerie Kegebein explained that Jennifer Lorvick, who had meant to come to this meeting, was unable to attend because her baby was ill. Jennifer expected to join the group at the next Council meeting.

Barbara -- CDC HIV/AIDS Update Broadcast / Open Position at AHP

- Barbara announced an upcoming CDC satellite broadcast: "HIV/AIDS update -- Key Issues in Counseling and Testing." She told the group that the broadcast would take place on May 22nd from 1:00-3:30pm Eastern Standard Time, and could be seen/heard at the AHP building at 15th and Folsom, which will receive it by satellite. (For more details, please see the flyer enclosed for all members.)
- Barbara mentioned an open position (for the director of the HIV Prevention Services Unit) at AHP, and submitted a job description for the minutes (enclosed for all members).

Gene -- Letter of Response to the "HIV Prevention Act of 1997" Bill

- Gene introduced a letter written by the current three HPPC co-chairs, on behalf of the San Francisco HPPC, in opposition to Representative Coburn's "HIV Prevention Act of 1997" (HR 1062). Gene reviewed the provisions of the bill, and informed the Council of (1) the proposed use of Medicaid funding to force states' compliance with the bill, and (2) the support given by the American Medical Association to the 1997 version of the bill. Gene explained that the HPPC co-chairs' letter of response to the bill was being sent to every California representative in Congress. (See the letter and attached cover sheet describing the bill, enclosed for those absent.)

  Steven Sams asked whether individuals could also download the letter and send it out, under their own names and letterheads, to representatives. Gene replied that those interested in downloading the letter could call the AIDS Office (554-9000) and ask for Judith Klain, who will handle these requests. In response to a question about the timeline for the bill, Gene stated that it would probably receive a vote in the next couple of months.

Jimmie -- AACAA Shutdown

- Jimmie announced that Asian American Community Against AIDS (AACAA) would officially be closing on May 31st, 1997. He said that he had been notifying people from the twenty or so agencies with which AACAA had program agreements. While letters would be going out around the end of April, he was also ensuring that people would hear by word of mouth. He said that AACAA could not accept any client referrals at this point. He went on to explain that he has some concerns about long-term clients who could be left without services. He had been having some trouble getting other agencies to take on such clients, due to the paradigm shift initiated by the HPPC (organizing services by the behavioral groups of clients) and to generally low resources. He said that he was looking at options for transitioning such clients through temporary services at other agencies, but that this approach would require cooperation both from the clients and from the other agencies. Jimmie stated that he might be calling around to investigate the possibility of other CBOs providing services to some of AACAA's transitional clients.

  Ellen asked whether there might be anything the Council could do to expedite the arrangement of transitional services for AACAA's former clients. Jimmie responded that

he had already been in the process of setting up these services, and that he planned to follow the recommendations given to him by the clients' case managers. He added that the question remains as to whether clients will agree to make the transition to other services. He emphasized that, given the timeline of the agency's shutdown, he could not continue his staff. Ellen suggested that HPPC members could collectively put out a call for an expansion of agency capacity to provide a safety net of services for AACAA's discontinued long-term clients. Jimmie added that, while he could only speak for himself and his own program, he knew that he was not alone in dealing with this situation of an imminent agency shutdown, leaving clients in an uncertain position for future services.

Chata -- Notification of Member's Absence / Spring Birthdays

- Chata explained that Bethsaida could not attend this meeting because she was on vacation.

- Chata noted that Polaris staff had provided a cake in honor of all the members celebrating spring birthdays (and for Kevin Roe, whose birthday fell on the day of this meeting).

Ellen -- Agenda Review

- Ellen provided a quick review of the agenda, to make members aware of the upcoming presentations and discussion items.

2. PUBLIC COMMENT

Prevention Services to the Transgender Community

Tamara Ching, a community activist who was also representing the SouthEast Asian AIDS Prevention Project (another agency being closed), offered public comment. She said that the SouthEast Asian AIDS Prevention Project serves the highest number of transgendered clients, with the highest-risk behaviors. She stated that she wants to ensure that any agency claiming to serve transgendered clients can back up their claims with appropriate services. She explained that some agencies have been claiming to do outreach to transgendered persons, in order to receive more funding, but that those agencies have never provided outreach in the Tenderloin, where the need is greatest.

Council Absences

Following her main line of comment, Tamara asked the Council to look at why there were so few people present at this meeting, and what it meant about the commitment of HPPC members. She noted that absent members were holding onto seats that could be filled by others who would attend.

HPPC Response to Public Comment on Council Absences

María said that she knows the rule in the Bylaws regarding Council absences and termination of membership. However, she felt that the Council should look into the issue of implementing that rule, since it seemed to have been happening behind schedule.

Chata informed the group that the issue of required attendance for continued membership had been addressed at the last co-chairs meeting, at which the co-chairs were given an attendance sheet and report from the Process Evaluation Team (which was recently assigned the task of tracking HPPC attendance). The co-chairs acted on the information by sending out letters inquiring into the intent of absent members to continue or to resign from the Council. Chata closed by saying that the co-chairs plan to adhere to the Bylaws around membership this year. Ellen put out an open invitation to HPPC or community members concerned about these issues to join the Membership Committee.

3. APPROVAL OF MINUTES FROM MARCH 27, 1997
With a quorum present, the minutes of 3/27/97 were approved by consensus.

4. CDC SUPPLEMENTAL DISCUSSION
Opening Exercise
To give context to this discussion, Ellen asked members to first think of someone in the client community with which they work, and to imagine holding that person in their right hand. Then she asked members to think of someone who is also HIV-impacted, but who is about as different as they could be from the person in the right hand, and to imagine holding that person in their left hand. Ellen closed the exercise by reminding the group that the planning members do is for the people represented in both hands.

Background Information: $719,000 in CDC Supplemental Funds Awarded for SF Prevention
Ellen informed the group that this discussion of CDC Supplemental funding had been prompted by the decision of the CDC to award an additional $719,000 in funding to San Francisco, for a twelve-month period. Ellen asked members to keep in mind the priority-setting process of the HPPC (see handout -- from p.469 of the Plan, enclosed for those absent) and the two primary goals of the planning process (eliminating HIV incidence, and ensuring that HIV prevention in San Francisco best meets the needs of people at highest risk), while carrying out this discussion of how to use the Supplemental CDC funding. She explained that members now had an opportunity to examine the HPPC priority-setting process, in conjunction with an analysis of service gaps and a consideration of community values. Members would be asked to start by brainstorming about how to allocate the funds, after which they would proceed to look at any implementation or logistical issues. Then the Council would decide on what to ask the AIDS Office to include in the scope of work (such as new research directions, funding for proposals, solutions to gaps in services, new conference opportunities, etc.), which would be submitted to the CDC by June 30th. With this introduction, Ellen opened up the floor for a one-hour brainstorming conversation about how to spend the additional $719,000 for prevention.

Question and Answer / Discussion of Where to Begin, and of Limitations Affecting This Discussion: Concerns About the Priority-Setting Model, the Summary Chart, and the Implementation of Council Recommendations
Steven asked whether there were any restrictions on the use of the prevention funding. Ellen said that she was not aware of any, but that the Council could consider possible implementation issues after going through the brainstorming process.

Jimmie asked for an explanation of the chart that the AIDS Office had recently mailed out to HPPC members, in preparation for this discussion. Ellen explained that the chart (enclosed for all members, since not everyone seemed to have received it in the previous mailing) represents a draft of the prevention programs funded through RFPs #015-96 and #016-96. The rough chart shows the strategies and interventions funded, as well as the behavioral risk populations they serve.

Liz (responding to a description of the numbers in the columns as representing the number of programs performing a given intervention for a given behavioral risk population) pointed out that the needle exchange appears to be conducted by six overlapping programs, when in fact it's all just one program. Ellen supported Liz' point, explaining that the numbers don't really stand for individual programs each serving a single population, but for any program that includes the population in its prevention intervention (and that same intervention may also be serving other

populations). In the chart, each different intersection of an intervention with a BRP is counted once; there are fewer programs than there are intersections of interventions with BRPs.

Sacul asked what defines the **"highest-risk neighborhoods."** Valerie responded that the neighborhoods were constructed and identified in RFPs over the last couple of years. All those neighborhoods currently described as "highest-risk" are ones that the AIDS Office solicited for interventions or that prevention providers described to the AIDS Office as high-risk. Put most simply, the "highest-risk neighborhoods" include those neighborhoods where people at high risk are known or thought to be found. The designations were made through a combination of the AIDS Office expertise and the expertise of the outreach providers it has funded.

Jimmie expressed his sense that the Council would need to know more than the information provided in the draft resource inventory summary chart, in order to examine what should be done with the new $719,000 in CDC funding. Jimmie noted, as an example of the chart's vagueness, that the number and kind of interventions serving transgendered clients could not be determined -- due to the grouping of transgendered persons with non-transgendered persons sharing a particular HPPC-defined behavioral category. Since all BRPs include transgendered persons (both pre-op and post-op), but not all services to a given BRP target the transgendered members of that BRP, the chart would need to clarify further about **which services specifically reach transgendered clients.** Jimmie also noted that the co-factors, while described in some detail in the Plan, do not directly influence the ranking of the BRPs. Finally, Jimmie said that the HPPC discussion of the Supplemental funds should be informed by the inventory of **CDC direct-funded interventions** (soon to be awarded), as well as the inventory of AIDS Office-funded prevention programs.

Chata expressed his wish to see the **ethnic groups, as well as the transgender groups,** served by the funded interventions. He felt (1) that the Council should engage in a close examination of the unmet needs and gaps in services left by the two RFP processes of 1996, and (2) that more agency-specific information should be provided in the resource inventory summaries used for this process.

María voiced her fears and concerns around this new Supplemental resource allocation process. She explained that she had not been around last year for the early discussions of RFPs #015 and #016, and that she hesitated to discuss how the money should be used without knowing of the **potential restrictions to be imposed by the CDC or the DPH/AIDS Office.** She pointed out that new funding brings more responsibility, and that the Council needs to know how it will be able to manage this responsibility -- so as to avoid the kinds of strife brought about by last year's RFPs and resource allocation process. In addition, María mentioned her **doubts about the usefulness of the Matrix (for priority-setting),** and her reluctance to employ an instrument which hasn't demonstrated its reliability or appropriateness for the task. She reported that she had heard testimony from people who had used the Matrix and who now feel that it doesn't work as intended. In particular, she felt that it would be important to revisit the issue of how to measure co-factors and covariates (such as ethnicity, immigration status, and level of acculturation) and factor them into the priority-setting process. She advised that the Council begin the discussion of Supplemental funding with some careful decision-making about what to take from the Year One and Year Two priority-setting/resource allocation processes. She didn't want the Council to repeat its mistakes.

Steven spoke up to say that he thought some of the questions members had raised about existing resources were already answered in the orientation binders given out at the beginning of the year,

although they were not all visible in the summary chart distributed before this meeting. He stated that a single-page chart could be useful to this discussion, but that it would have to be improved.

Sacul said she was curious about how the Council had arrived at some of its **frequency figures** for particular behaviors. Ellen noted that the first-year Council had struggled with trying to find data from a variety of sources, and had chosen to focus on risk behavior rather than on identity. The Council looked at the mechanics of viral transmission, to come up with the behavioral groupings. (In 1994, Harder + Co. technical support staff ran a literature search, consulted the 1992 Consensus Report, and conducted phone interviews with local researchers -- to yield data for use and adaptation by the HPPC Priority-Setting Subcommittee, in setting the basic Matrix figures.) Ellen noted that the Council had developed the Behavioral Risk Assessment requirement partly in order to gain current and local provider data that could be plugged into the Matrix.

Chata said that the Council should know more of the characteristics (as described by covariates and co-factors) of the populations on which data is collected. He summarized that **color should be brought back into the process**. Ellen responded that there is not always much data available by ethnicity or by co-factors. She said that the HPPC approach to integrating color into the process had been to empower local agencies to bring their **population-specific data** to bear on the Matrix. She reminded the group that the Matrix combines the factors of prevalence, population size, frequency, and relative risk. Recognizing that it is false to claim that everyone is at equal risk for HIV, the HPPC attempted to find the sites of greatest risk through this priority-setting method.

Sacul pointed out that **African-American women** are rapidly dying of AIDS, but that there is still very little funding allocated to HIV prevention services for their population. She stressed that people cannot all be lumped together under behavioral categories. She expressed a concern that too much of the San Francisco prevention funding is going toward services for gay, white males.

Valerie told the group that the chart with prevention funding allocations had been put together for the Council as a snapshot of available resources. It is only one of a series of draft charts that the AIDS Office has compiled for the Resource Inventory. Once it is possible to account for all sources (including CDC direct funding), the charts will be revised with the new information, so that the Council can make fully informed decisions. Valerie added that the Council would need a breakdown of the allocated funding **by intervention type, by race/ethnicity, and by gender.** She stated that AIDS Office staff would provide this information to the best of their ability, based on the prevention contracts (some of which were, at the time of this meeting, still under negotiation).

In response to the expressed concerns about the usefulness and validity of the Matrix for priority-setting, Valerie noted that the data sources for the Matrix included information received from front-line workers in the field of HIV/AIDS services.

Liz spoke to say that the presentation of information in the one-page chart that members had received was deceptive, in that it appeared to offer more specific information than it could offer. She pointed out that some programs appear in the chart to be serving specific populations, when in fact they work with the general population. (For example, agencies may include women in their target audience, but may not provide services that focus on women and may not even have many female clients). Liz also raised a concern about the Behavioral Risk Groups as the only organizing model, in that they do not account for **women who have sex with male IDUs** as a group at elevated risk for HIV.

Gene reminded the Council that (by June 30th) the AIDS Office would have to submit the scope of work for how San Francisco would spend the $719,000, and that the CDC would have to give its approval. Ellen added that the **Council would have to make its decisions by May 30th,** in order to allow time for the scope of work to complete the internal DPH and AIDS Office approval process.

Jimmie asked the group to recognize that the bottom line is that the money is available to San Francisco, and that **the allocation decisions will have to be made, if San Francisco wants that prevention funding.** He said that, while the allocation decision-making process would certainly not be an ideal one (due to the timeline and other constraints), the Council could ask for sufficient information to allow it to make a reasonable decision. Jimmie then asked whether a special HPPC meeting would need to be devoted to this issue of spending the Supplementary CDC funding. Ellen responded that the Council had a one-hour meeting scheduled for the 17th of April, as well as two meetings in May.

Chata suggested that the Council could develop an **ad hoc committee** to deliberate on the question of the Supplementary funding allocation, and to bring back recommendations to the full Council for a vote.

Jelousy made the following two points:

1) that it would be helpful to show more detail with regard to the majority of the client population served by each funded agency, or **the proportions in which different ethnic/racial and gender populations are served** by each agency; and
2) that the Council should begin to focus more on **effectiveness** of prevention interventions, and on ensuring the broad dissemination of newer prevention information (e.g., around the uses of the female condom), so that it effectively reaches populations at risk.

Proposals for Use of the Supplementary Funding

Ellen urged the Council to begin to compile a brainstormed "wish list" of possible uses for the new funding. In view of information that she had read from recent studies on the impact of STDs on HIV transmission {i.e., (1) when HIV-negative people with STDs are treated for their STDs, they become biologically two to five times less likely to become infected with HIV; and (2) aggressive STD treatment of a population can lead to a 40% decrease in HIV seroincidence}, Ellen proposed that **the new funding might be used to develop a stringent STD linkage component to local HIV prevention.** She argued that the focus on STD treatment might create an effective support for existing prevention efforts.

Barbara offered the suggestion that **the funding could be used to build linkages and referrals,** since a single prevention intervention is often insufficient. She raised the possibility of soliciting new proposals for linkages and referrals, which could then be funded with the Supplementary money. Barbara then mentioned two concerns:

1) that members at the next HPPC discussion of the Supplementary funding would need to be caught up on what had happened at this discussion; and
2) that there would be no guarantee of the implementation of HPPC guidance on the use of the funding. Barbara wondered what would happen once the Council pronounced its final decision on the issue.

Gene responded that the CDC expects thorough involvement of the HPPC in the Supplementary funding allocation process. The Council will review the proposal and write a letter of concurrence or non-concurrence.

Dawn suggested that part of the explanation for the link between STD treatment and decreased HIV seroincidence might lie in the **prevention case management (PCM)** received by clients for STD treatment. She thought that the behavioral interventions and the education given to STD clients might be successfully keeping those clients from repeating their high-risk behaviors.

Chata said that, on the one hand, he would definitely like to see funding put into **evaluation,** to learn what prevention interventions work for which communities. However, he stated that the **bottom line should involve serving people in San Francisco.** He suggested that the Council examine unmet needs and gaps in services left by RFPs #015 and #016, in order to decide how to correct some of the mistakes of last year.

Jelousy noted that the methods that may have been used for PCM given to STD clients could shed some light on general approaches that would be valuable for prevention.

Ahimsa expressed his desire to **fill the gaps in services (particularly for women and for people of color)** with the Supplemental funding. He also wondered whether the money could be used to help with the **transitioning of clients** whose services are being withdrawn as a result of the provider agencies closing.

Jimmie addressed Ellen's recommendation around the use of an aggressive STD treatment approach to assist with HIV prevention. He said that the relationship between STDs and HIV is already embodied in the Council's understanding of STDs as a co-factor for HIV infection. He added that the list of other co-factors for HIV infection is huge, and that the sole-sourced STD City Clinic is the only municipal clinic treating people for STDs. He said that the Council would have to **look at the question of what services San Francisco already has, and what it needs.** Jimmie went on to say that he had tried to expand the list of co-factors for himself, and had realized that one could go on indefinitely refining and expanding it. For example, there could be many different possibilities for what constitutes a "risky partner." He suggested that the Council consider the most common, significant co-factors for HIV infection, since the list may need to change over time.

María voiced her sense that the Council should begin by using the funding to cover service gaps (from the last two RFPs), based on co-factors (and covariates) -- starting with ethnicity and culture. She said it seems better to use the money to **start a new program, in order to cover the clients left without services.**

Steven offered three options for how the Supplemental funding could be used:

1) He remembered that when Lyn had presented the Matrix figures to the Council, he had asked where the numbers came from, and she had explained that the figures had involved some extrapolation from existing data, and some guesswork. He expressed a wish to see some of the new funding spent on **arriving at numbers in which the Council could place more confidence** -- or at least on finding out what steps should be taken in order to get those answers. He thought the new funds could allow S.F. to get at the proper questions.

2) Steven also suggested that the funding could be spent on gaining **referral** information (e.g., what are the most efficient methods of referring clients on to other services?), and looking at ways to take referrals into account for HIV planning.
3) He proposed that funding could go into research on what factors keep the highest-risk HIV-negative people from seroconverting. He thought that prevention efforts could benefit from greater knowledge of **how high-risk negatives beat the odds and stay negative.**

Joel apologized for having arrived late, and went on to speak about the cause of gaps in prevention services. He suggested that **the HPPC's decision to focus on behaviors, rather than on specific populations, might have led to the current gaps in services.** He stressed that, in addition to behaviors, the context for behaviors (e.g., a set of fears or needs, or issues of power and of belonging) can be significant. The contexts of acts relate to the thought processes of the actors, and to the causes of the behaviors. While Joel wanted to recognize the extent of the work that the Council had put into its model for priority-setting, he said that he thought the problems around resource allocation had arisen as a result of the Council's overemphasis on behavior, at the expense of recognizing differences between specific populations. He added that he had seen an HIV prevention plan (for Washington state) which prioritized populations (groups of people with something in common other than their behavior) for prevention efforts.

Joel went on to describe a round of RFP planning discussions that the CDC had held about a year ago for its RFP process (#704). He stated that, as a result of feedback given at those meetings, the CDC had decided not to include specific regions or specific populations in its RFP criteria. He noted that elevated HIV incidence wasn't considered in the CDC RFP process, either. Joel expressed his concern that the CDC pre-decisional site visits to applicants for direct funding suggested that the agencies to be funded include very little population-specific prevention programming (for people of color and/or for gay, lesbian and transgender groups). He had learned that, for CDC RFP #704 funding, no African American provider agencies were being considered in New York City. In San Francisco, pre-decisional site visits were being made to just four organizations -- none of which are African American population-based, only one of which is API, and only one of which is Latino (and it does not specifically target gay, lesbian or bisexual Latinos). Joel explained that -- while he could accept the idea of one organization not receiving funding, as long as another organization would be funded to provide services to the same population -- he felt that some populations had fallen completely through the gaps, and had not been picked up by funded organizations. He noted that the San Francisco HIV Prevention Plan had served as a national model, and that its impact was being felt in other RFP processes now.

To prevent these kinds of gaps from occurring in future resource allocation processes, Joel suggested that proposal review committees not only look at the quality of proposal essays, but conduct site visits with the applicants (which would include looking at their demographic data). He closed by stressing that the **additional funding should go to the unserved groups**, and that the next step would be to look at how prevention programs can best affect behavior (he added that he believes culture to be at the center of these matters).

Liz stated her view that what is at issue here is **class and poverty (which cut across identity and cultural groups)**, and that social and economic communities -- rather than just gender groups or ethnicities -- need to be seen as specific populations, with shared risk levels and needs for prevention. She argued that the complexities of the issues around risk and culture demand a complex approach to prioritization for prevention.

Chata reminded the Council that the local API population makes up about 29% of San Francisco, that the Latino population alone encompasses 15-20 different cultures and languages, and that the Native community in the Bay Area is the third largest in the nation. He used these examples to illustrate his point that San Francisco is enormously diverse and that culture is of great importance. He asserted the need to address culture in order to meet the prevention needs of the city.

Jelousy spoke about the Glide testing center, which just extended its evening hours and has placed an emphasis on STDs in its counseling and testing program. He said that the testing program emphasizes counseling and prevention. He added that, when people come in for an HIV test, it is often their first opportunity for counseling, or even for talking with someone about sex. He expressed his concern that needle exchange and methadone clinic clients are still not receiving counseling with their services. He stressed the point that people need opportunities to talk about their issues, in order for prevention services to be most effective. While he agreed with other members that culture has an unquestionable impact on risk and on prevention, he added that **clients cannot begin to make a behavioral change without some form of counseling.**

Vic apologized for his lateness, and spoke about the question of **who ends up representing specific populations.** He said that, in his understanding of resource allocation, a central establishment doles out funding to agencies to deal with problems in the jurisdiction. He asked the Council to look at who is selected to represent people of color or lower-income people. He expressed his own dismay at seeing the communities in greatest need of support being assigned to agencies which have turned in empty, non-specific proposals. He said that he had witnessed this happening in New York City as well, where an executive director impeded the work of a valuable community-specific prevention project, and kept it from publishing.

Summary
Ellen recapitulated the **types of data** that members had mentioned as necessary for Council decision-making on the use of Supplemental CDC funds:

- breakdown of prevention funding by population (race/ethnicity and gender) for existing contracts;
- information on the co-factors addressed by contracts;
- information on CDC-funded prevention programs in San Francisco;
- gaps in services left by the #015 and #016 RFP and awards processes; and
- agency-specific information and client demographics, for funded contracts.

Having heard the list above, Liz added the following item:

- breakdown of the demographics of funded contracts to show whether (and in what proportions) they serve youth and transgendered persons.

Ellen then listed the following **funding areas** that she had heard members mention as possibilities:

⇒ prevention for females who have sex with male IDUs;
⇒ STD treatment;
⇒ linkages and referrals;
⇒ PCM;
⇒ prevention for populations which fell through the gaps of RFPs #015 and #016;
⇒ prevention for women of color;
⇒ transitional services for clients whose provider agencies are closing;

- ⇒ enhanced epidemiological profiles (stronger data);
- ⇒ data collection on high-risk seronegatives who remain seronegative over time;
- ⇒ prevention for women, people of color, and youth (with particular attention to the high-risk subgroups within these larger populations);
- ⇒ prevention for lower-income or impoverished socio-economic communities; and
- ⇒ counseling services for people at risk for HIV.

Having heard the list above, Liz added the following item:

- ⇒ prevention programs for young MSMs using speed/methamphetamines;

and Tamara Ching (guest/public commenter) added:

- ⇒ commercial sex workers.

At this point, María spoke up to ask what would be the official role of the Council with regard to the Supplemental funding allocation. She wanted to know whether the Council could decide, or simply make recommendations to the AIDS Office. At the very end of this meeting, during the final announcements, Chata responded to María's question with the following clarification:

It is within the purview of the HPPC to decide how to use the CDC Supplemental funding. The AIDS Office application must include a letter of concurrence from the full Council.

Ellen asked who on the Council would be willing to serve on an ad hoc committee making recommendations to the full Council for the use of the Supplemental funds. In response to a member's question about the time commitment involved, she guessed that the people serving on this ad hoc committee would have to attend an additional two to three meetings (total), in order to complete this task. Jimmie said that, while he would like to be able to participate, he could not serve on three committees simultaneously. At this meeting, the following members volunteered to join the **ad hoc committee** to make recommendations on the use of the additional CDC funds:

1) Joel Reyna
2) Sacul L'Adnbre
3) Liz Highleyman
4) Askia Muhammad
5) Jelousy Jiggetts
6) Steven Sams
7) María Rinaldi
8) Chata (Ronnie Ashley)
9) Ellen Goldstein
10) Gene Copello

5. BREAK

6. GUEST PRESENTATION: TRANSGENDER STUDY (T-CHP)
Ellen gave a brief introduction to the presenters for the Transgender Study, or Transgender Community Health Project (T-CHP).

Background (Please see presentation notes, enclosed for all members, for further details.)
Use of the Term "Transgender"
Transgender Program Coordinator (and former HPPC member) Kiki Whitlock of the API Wellness Center offered the Council some background on this study. First, she explained that "transgender" is an umbrella term that can be applied to different gender identities and gender presentations and different sexual orientations. In other words, a transgendered person may be male or female (or may identify outside of the confines of those two genders), and may be heterosexual, homosexual, bisexual, pansexual, asexual, queer, or questioning.

Preliminary Focus Group to Assess Needs (Formative Research)
Kiki informed the group that, in August of 1994, the HPPC had decided on the need for a preliminary transgender focus group, to determine the needs of the transgender community. This focus group was conducted by the Support Center, and it constituted the first step toward gathering data for the local transgender community.

Arrival at the Inclusion of Transgender Populations in the 12 Behavioral Risk Populations
Kiki reported that, in 1994 and 1995, she had made a move from serving on the Strategies and Interventions Subcommittee of the HPPC to working with the Priority-Setting Subcommittee, which was prioritizing the twelve behavioral populations in terms of their risks for HIV and their needs for prevention services. She explained that input and involvement from members of the transgender community, together with work on the part of Harder + Co. staff and committee members, paved the way for inclusion of transgender populations in the 12 BRPs. This model of transgender populations as integral components of all 12 behavioral risk populations was then used in the two 1996 RFPs.

Prioritization of Research by the Epidemiology and Research Committee (1996 HPPC)
In early 1996, Patrick Forte (a member of the FTM transgender community) was appointed to the HPPC and began to chair the Epidemiology and Research Committee. This committee used a set of criteria and a voting process for ranking, to choose priority studies and research directions for San Francisco. In the early part of this process, committee members agreed that both a risk behavior and a prevalence study of the transgender community would be a high priority.

Decision to Conduct 11 Focus Groups at Service Sites
Kiki reported that Gene Copello convened an advisory committee in 1996 with HIV service providers and consumers in the transgender community. The committee coordinated 11 focus groups convened at transgender service sites throughout the city. The findings of the focus groups were presented in November 1996 by three members of the transgender community, to the Mayor's HIV Health Services Planning Council. Kiki added that findings and recommendations would be presented to the HPPC in the future.

Next Steps: CAB Meetings, Hiring of Staff, Beginning of Data Collection Process
In February of 1997, a T-CHP community advisory board (CAB) convened for the first time with the AIDS Office. The fifth meeting of the CAB was scheduled for late April. Kiki added that the AIDS Office would soon be hiring five persons of different races and genders, with transgender community service experience, to conduct interviews and perform HIV testing with a target sample size of 500 local transgendered persons.

Kiki turned to introduce Kristen Clements, the AIDS Office Principal Investigator on the T-CHP study.

Current Activity and Directions of T-CHP

Dissemination of Focus Group Data

Kristen Clements noted that the focus group data would be issued in a bound report, which would go to all local HIV service providers, as well as other health care/service agencies and planning councils.

Basic Description and Progress of Research Project

Kristen said that, to date, T-CHP had largely been engaged in planning, and in developing instruments and protocols. She distributed a handout (enclosed for those absent) describing the study. She summarized that the study would gather quantitative data, to provide information on the level of HIV risk faced by the transgender population of San Francisco. Previous studies, she explained, have primarily included MTF sex workers, and have used very small sample sizes. T-CHP intends to gather interview and testing data from a minimum of 200 MTF and 200 FTM transgendered persons.

Interviewing Instrument

Kristen told the group that the project had already piloted one 45-minute instrument, and that it would pilot the instrument again, before using it to gather data for the study. The instrument includes questions covering the respondent's sociodemographics, health status and access to health services. It also asks risk behavior questions and questions regarding the specific needs of the transgender community. (In the analysis stage, T-CHP will examine whether the risk behavior responses differ significantly by subpopulation.)

Counseling and Testing Component

Because T-CHP also hopes to gain estimates for prevalence in the local transgender community, the staff will conduct an oral HIV test, which is extremely comparable in its reliability to the blood draw (but is more comfortable for some people). Kristen noted that this HIV testing method, which works by collecting a sample of cheek cells, would probably begin to be used by many CBOs. She said that Glide is one site piloting the oral HIV test, which may also be able to function as a test for Hepatitis B.

Recruitment Methods, and Participation Incentives/Benefits

To gain subjects for the study, T-CHP will be using snowball recruitment (so that participants may be recruited by other participants), and working with agencies and outreach workers to spread word of the study. Direct recruitment will take place at chosen venues, listed in the handout. Kristen noted that the project has a 1-800 number, which people had already begun calling to schedule interview appointments (although the number was not yet active at the time of this meeting). Appointments will take place at seven service agencies (listed in Kristen's handout, under "Recruitment/Interview Sites"), which will be rotated each week. One motivation for the choice of these agencies as interview sites is that some study participants may be able to be linked into appropriate services at those agencies. Kristen explained that the project has an extensive referral component. She added that T-CHP may seek to hire interviewers who are actually client advocates, in addition to being sensitive people who already have a good track record of work in the transgender community. The project has incorporated incentives for (1) completion of the interview/ counseling and testing session, (2) appearance at a return appointment for test results and post-test counseling (although this incentive is small and is mainly intended to cover the costs of any transportation taken to the appointment site), and (3) snowball recruitment of eligible participants into the study.

Next Steps
Kristen informed the group that she expected to conduct the hiring and extensive training of interviewers in May, for a June start-up date for interviewing with testing and counseling. She added that the project might have to renew its recruitment efforts in time, in order to reach the target number of both FTM and MTF participants.

Question and Answer
Pre-Operative and Post-Operative Distinction/Venues for Recruitment
Steven asked whether the sample would be divided according to participants' status as pre-operative or post-operative, and received a confirmation that it would be broken out in this way. Steven also asked whether the project staff had considered using electrolysis clinics as recruitment sites. Kristen responded that this possibility had not yet been raised, but that she could look into it. Kiki said that the project was attempting to reach various types of community venues, service sites and organizations, and that many contacts had already been made.

Pansexuality
Sacul asked about the meaning of the term "pansexual," and Kiki explained that it is a self-identity, which some people adopt because it allows for more than two gender possibilities for sexual partners (whereas "bisexual" suggests a duality of gender).

Final Ranking of Studies
Liz clarified that the transgender study did not make the Epidemiology and Research Committee's final list of five highest-priority studies, although the transgender study had been listed as a priority earlier in the committee process. Sacul confirmed this point, adding that the suggestion for a new behavioral and prevalence study of the transgender community had been dropped as a result of the committee's awareness that the AIDS Office was already beginning work on such a research project (T-CHP) with the transgender community.

Early Involvement of Transgender Community in Informing the AIDS Office and HPPC Process
Tamara reviewed that the whole process which set T-CHP in motion began early in 1996, and that she and Kiki had been working, from a much earlier point in time, on educating various members of the AIDS Office and HPPC about transgender sensitivity and community needs.

Prevention of Repeat Subjects
Jelousy asked, in view of the monetary incentives being used to gain participation, whether the people working on T-CHP had already considered setting up mechanisms to ensure that nobody could be counted more than once as a respondent. Kristen answered that the additional time required for tracking of participants had already been built into the interviewing schedule. Kiki added that the demographic questions to be answered in the interview would help clue project staff into any attempts at repeating entry into the study. Interviewers will also check with each other to ensure that they are not jointly interviewing and processing the same participants.

Oral HIV Test Concerns
Joel asked about any concerns that might have been raised regarding the possible interpretation of the oral HIV test as suggesting that HIV can be transmitted through saliva. Kristen said that that concern had not arisen, although there was some misapprehension about the test not being very accurate. The oral test had been devised as a method that would make testing more approachable for communities or individuals who are not comfortable with having their blood drawn. Kiki

emphasized that the testing would be accompanied by HIV education and prevention information, including basic information about the oral HIV test and about how HIV is and isn't transmitted.

Available Information -- Reports
Tamara said that she would leave the two reports ("Investigation into Discrimination Against Transgendered People," issued by and available from the Human Rights Commission of the City and County of San Francisco in September 1994; and "Transgender Protocol: Treatment Services Guidelines for Substance Abuse Treatment Providers," issued by the Transgender Protocol Team of the San Francisco Lesbian, Gay, Bisexual, Transgender Substance Abuse Task Force in May 1995, and available from CSAS) with the HPPC co-chairs[1].

Recruitment Strategies, and Preventing Entry into the Study Under False Pretenses
Barbara asked whether T-CHP would like to be able to have a person stationed at AHP counseling and testing sites, to do more recruitment of potential study participants. Kristen responded that the project is mainly relying on primary recruitment, and is trying to get flyers out to service agencies and to get the word out in the transgender community. She said that it would be less helpful to try to recruit in agencies in which the clients do not primarily identify as transgender, because there is a chance that non-transgender clients might try to enter the study for the incentives. Since one of the main criteria for eligibility is self-identification, there is a need for caution around recruitment sites and methods. For example, the project will not recruit participants at the annual L/G/B/T Freedom Day Parade, although it will manage an informational booth at that event. Kiki added that the transgender community has already been made aware of the upcoming study.

7. HPPC PROCESS EVALUATION REPORT

Summary of Process Evaluation Methods and Documents (Handout)
Kathleen Roe began by calling members' attention to the handout, "Process Evaluation Methods and Documents," (enclosed for those absent) which summarizes the four basic data collection tools used by the Process Evaluation Team. It also describes the HPPC Log, a regularly-updated report produced by the evaluators so that HPPC members can easily refer to past votes and meetings.

Collecting of Feedback at Meetings
Kathleen explained that the Team will be distributing two separate types of HPPC Meeting Evaluation forms at each meeting: one (lilac-colored) for Council members, and another (white) for non-Council members attending the meeting. Since members and guests are likely to have somewhat different perspectives on the meeting, the evaluators thought that it would be valuable to keep separate records of their input. Members, AIDS Office staff, consultants, and guests/outside observers can all fill out the Participant Dialogue forms. Kathleen pointed out that the back page of the form includes a series of boxes for respondents to use to identify their role, so that their comments can be interpreted in context. Kathleen requested that all those filling out the forms try to write as clearly as possible, in order to ensure that their input is reported fully and accurately.

HPPC Log
Kathleen also distributed the first installment of the HPPC Log for 1997, to which additions will be be made each quarter (or more frequently, if requested). She explained that the Log information comes from the observations of Council participants, the observations of the Evaluation Team, and the minutes. The Log includes summaries of all formal meetings of the Council, in chronological

[1] The reports were given to Polaris logistical support staff, to keep on file for the HPPC. Members are welcome to access the Polaris, Inc. files on the HPPC at any time, by appointment.

order and with meeting numbers. Committee meetings are also beginning to be added to the Log -- and even co-chairs meetings will appear in it, now that Kathleen Roe is attending those meetings and can keep her own record of them. Kathleen explained that members should keep the first Log installment with its cover page, and should simply add future installments at the back.

Interviews
Process Evaluation Team members had contacted Council members about setting up appointments for April phone or in-person interviews. Kathleen noted that everyone should already have an appointment by this time, and she added that the general content of the interviews was displayed in the handout, "April Council Interviews: Summary of Key Questions." She informed the group that committee-specific questions would also be included in the interviews.

Council Input into Process Evaluation Activities
In closing, Kathleen Roe reminded the Council that her team is always open to hearing any other process evaluation suggestions from members.

8. GUEST PRESENTATION: POST-EXPOSURE PROPHYLAXIS

Introduction
Dr. Mitch Katz, Director of the AIDS Office, opened his presentation on post-exposure prophylaxis by stating that the Council would have a great deal to offer the AIDS Office in terms of policy guidance and ideas for how to integrate this new "morning after" treatment option into prevention.

Post-Exposure Prophylaxis -- What it Is, and What it Can Do
Dr. Katz explained that post-exposure prophylaxis refers to the use of anti-retroviral drugs on a person who has very recently been exposed to HIV. It has been offered to health care workers for the past three or four years, to try to lower the likelihood of seroconversion following a needlestick. A study of health care workers who had suffered a needlestick exposure to HIV showed that administering AZT alone reduced seroconversion by 79%. While Dr. Katz cautioned that the treatment was by no means perfect, he summarized that the study demonstrated that post-exposure prophylaxis could (and apparently does) work.

After the release of the report on the study of health care workers, the AIDS Office began receiving calls from prevention providers, clients, and others -- regarding the possible value of post-exposure prophylaxis for people who know that they have just been exposed to HIV through sexual contact or injection. Dr. Katz said that the AIDS Office believes that the benefits of post-exposure prophylaxis in those situations would be similar to the benefits experienced by occupationally-exposed health workers.

How It Works
At this point, Dr. Katz presented the Council with some of the theory behind the functioning of post-exposure prophylaxis. He described research performed on female macaques, who had a simian form of the virus inserted vaginally. The virus was picked up by cells in the vagina, and carried from there to the lymph nodes of the macaques. The researchers observed that the virus disseminated into the bloodstream after about Day 5 of the experiment. In theory, the use of anti-retroviral drugs in the first days after exposure to HIV may be able to keep the virus from replicating itself and traveling into the bloodstream. Post-exposure prophylaxis would not eliminate the HIV entirely, then, but would keep the virus in the body at minimal levels, which would basically prevent the exposed person from seroconverting. Dr. Katz described this effect as

similar to the effect had by antibiotics, which do not kill off all of the bacteria targeted, but reduce their number so drastically that the body can independently handle those bacteria that remain.

Critical Issues for Prevention

Dr. Katz began the discussion of the relationship between post-exposure prophylaxis and prevention by stating that it is unclear how the availability of a "morning after" pill for HIV would affect communities at risk and their behaviors. He reported that the AIDS Office had most often received post-exposure prophylaxis inquiry calls about situations in which a discordant couple (one HIV-positive and one HIV-negative partner) had been practicing safer sex but had experienced a condom break. Mitch pointed out that in these situations the issue was somewhat clearer, because the couple had already been committed to practicing safer sex. He explained that it would be harder to figure out **how to incorporate the existence of post-exposure prophylaxis into prevention messages.** As he explained, the true prevention message is that prevention providers will work with their populations to keep people from engaging in risky behavior. However, now providers would have to add that, if a person does engage in risky behavior, there is this other possibility for staying uninfected. This complicates the message and may make it more difficult to understand or to heed. On the other hand, Dr. Katz explained, **nobody wants to deny a valuable treatment to clients because of the problems that it may cause for the message of prevention.** Another concern that Dr. Katz raised is that clients may actually have little access to this form of treatment, so it may be unfair to hold it out as a cause for great hope and relief.

Handouts

Dr. Mitch Katz presented the Council with handouts (enclosed for those absent) providing more information and discussion on post-exposure prophylaxis. He explained that the first handout was a copy of the B.A.R. forum on the issues around post-exposure prophylaxis, while the second handout was a copy of an article that he had written with his colleague, Dr. Julie Gerberding, for The New England Journal of Medicine. In closing, he mentioned that physicians are already prescribing this treatment for sexual or injection-related HIV exposure, so it is now a reality.

Question and Answer

Period of Treatment

Jelousy asked about the actual length of time for which a person would take the anti-retroviral drugs, for the purpose of post-exposure prophylaxis. Dr. Katz responded that, at this point, people are being told to take the drugs for a 28-day period.

Medicines Prescribed

María asked about the dosage recommended, and Dr. Katz said that people are given two medicines to take (generally AZT and 3TC). However, if the person has experience with those medicines or has a very high viral load, then it is usually recommended that the person also take one protease inhibitor. He added that the consensus on which are the best medicines to use will probably change over time, but that the example of the health care workers will probably continue to serve as a model for this kind of treatment (since the data still rest with that study).

Decrease in Seroconversion

María then asked about how the study had arrived at the conclusion that health care workers using the post-exposure prophylaxis were 79% less likely to seroconvert. Dr. Katz explained that all of the health care workers had suffered a needlestick exposure to HIV, and that some had later seroconverted while others had not. Among those who did not seroconvert, the proportion who had been treated with anti-retroviral drugs for the exposure was significantly higher.

Issues of Payment for Treatment
María raised the question of who would pay for the treatment. She mentioned the possibility of Medical, but added that it would be harder for undocumented immigrants to get this treatment. Mitch Katz responded that the candidates for post-exposure prophylaxis, whether documented or not, are generally not eligible for Medical, because they do not yet have any serious illnesses. He said that it was possible that insurers would not cover post-exposure prophylaxis, because they could claim that it has not been proven effective. At this early stage, drug companies are contributing the drugs. However, Mitch emphasized the need to find funding for counseling to accompany the drug treatment. He reported that the AIDS Office was applying to NIH and other funding sources for money for post-exposure prophylaxis and counseling. He added that drug companies are only donating the drugs now because they see this as a future market for their products; soon the donations will need to be replaced with new means of paying for the treatment.

Concerns About Lack of Sound and Comprehensive Research Data
Vic expressed his concern about the lack of definite knowledge about this new treatment and its effects; he felt that providers should not just be handing out a bunch of pills and hoping for the best. He mentioned that there are issues about drug types, toxicity, dosages, etc. For these reasons, he hoped that there would be more studies on post-exposure prophylaxis, beyond the one that was conducted with health workers. (As Mitch Katz had pointed out earlier, the methods and reliability of that study have been heavily questioned.) Dr. Katz responded that providers should probably not expect to see any stronger studies of post-exposure prophylaxis for some time, if ever. Because of the already very low likelihood of infection from a single needlestick exposure, a great number of participants would have to be enrolled in any health care worker study, to begin to see the effect of the treatment. In addition, the health care workers did not want to be randomized -- they wanted to know whether they would be taking the anti-retroviral drugs or not (because of the side effects of the drugs and other concerns). Dr. Katz added that, before post-exposure prophylaxis can be researched in community studies, it will probably be necessary to look further at efficacy. He pointed out that, in any such study, thousands of participants would have to be enrolled, and they would also have to agree to be randomized.

Effectiveness from Time of Exposure / Effects of Treatment on Responsiveness to Anti-Retrovirals
Steven asked (1) about the actual time frame within which post-exposure prophylaxis would be effective (e.g., the morning after, the afternoon after, etc.), and (2) about what this treatment could do to a person's longer-term ability to benefit from anti-retroviral drugs -- should they later seroconvert. Dr. Katz stated first that it is hoped that post-exposure prophylaxis will be viewed as just one part of a prevention intervention. It may provide an incentive for people to access services and to interact with prevention providers. In answer to Steven's first question, Mitch Katz said that the average time between exposure and treatment (in the health care workers study) was four hours. He stated that there is a general consensus that sooner is better, for the effectiveness of post-exposure prophylaxis. The literature is beginning to refer to a cutoff point of about 72 hours after exposure. Dr. Katz noted that, the longer the time from exposure, the less likely the treatment is to prevent seroconversion, and the more weight should be given to the disadvantages of taking the drugs (side effects). In response to Steven's second question, Dr. Katz suggested that most physicians in the position of treating someone for HIV after that person had undergone post-exposure prophylaxis would recommend two new anti-retroviral drugs for the patient. However, he noted that a person's exposure to a drug in the 28-day period required for post-exposure prophylaxis would not approximate an exposure to the same drug through long-term treatment.

Post-Exposure Prophylaxis and Testing, Anonymity
Jimmie asked whether clients receiving the post-exposure prophylaxis would be able to remain anonymous, through the treatment process and HIV testing. He suggested that, on the one hand, the availability of post-exposure prophylaxis might bring in exposed clients and might alleviate their stress around getting tested and returning for results. On the other hand, he was concerned about the possibility of false negative results, and wondered about the role of an assessment to determine whether some clients should be advised to return for later testing -- because of the window during which results cannot be certain. Dr. Katz responded that, if the AIDS Office does a service demonstration project, all participants will probably need to give a name, but the name could be an alias, rather than a real name. Dr. Katz noted that other people would use a personal physician, in which case there may be confidentiality but not anonymity.

Access to Information
Dawn offered a closing comment to the discussion. She said that it is important to give people the information that is available. She felt that any available information on the treatment should be shared with prevention providers, and that clients should be permitted to make their own choices about how to use it. She stressed that providers cannot withhold information in order to protect clients.

9. CLOSURE
Chata made final announcements about upcoming meetings. In addition to the meetings already posted in the calendar and at the top of these minutes, he announced a first meeting of the ad hoc committee to look at Supplementary funding allocation: April 14th, from 11am-1pm.

Enclosed with These Minutes (for all members):
- CDC announcement of the May 22 satellite broadcast on issues in Counseling and Testing;
- UCSF Employment Opportunity flyer with job description;
- Resource Inventory Chart of Prevention Services Funded through RFPs #015 and #016
- "TCHP Background" handout from Kiki Whitlock's presentation;

Enclosed with These Minutes (for those absent):
- Summary of Coburn bill, and response letter from the co-chairs, for the entire HPPC;
- "Recommendations for Priority-Setting," p. 469 from the Plan;
- Handout from Kristen Clement's presentation, "Transgender Community Health Project;"
- "Process Evaluation Methods and Documents;"
- "Evaluation Results" for 3/27/97;
- "Participant Dialogue" for 3/27/97;
- "Community Outreach" results for 3/97;
- "Year 4 HPPC Log: Quarter 1;"
- "April Council Interviews: Summary of Key Questions;"
- "The Morning After" forum from the Bay Area Reporter;
- "Sounding Board" on post-exposure prophylaxis from The New England Journal of Medicine; and
- Castro Lions Club Newsletter (April 9, 1997).

Minutes Recorded by: Mary Irvine
Minutes Approved by: AIDS Office Co-Chair Gene Copello and Community Co-Chair Chata

Note: Location Change!!!

HIV PREVENTION PLANNING COUNCIL MEETING

April 17, 1997
3:00 PM 6:00 PM
AIDS Office
25 Van Ness Avenue (Room 330A)
San Francisco

Meeting called by: **Co-Chairs:**
Gene Copello
Ellen Goldstein
Ronnie Ashley (Chata)

Please read: **Agenda and minutes of April 10, 1997**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Food/Welcome/Introductions/Announcements	Ellen Goldstein	3:00 - 3:05 PM
2. Guest Presentation: Prevention PSAs	David Weissman	3:05 - 3:25 PM
3. CDC Supplemental Discussion: Options	Ellen Goldstein	3:25 - 4:00 PM
4. Break		4:00 - 4:05 PM
5. Committee Meetings		4:05 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC & Committee Meetings :

Thursday, May 8, 1997, 3-6 PM, First Unitarian Church - Franklin & Geary Streets

Thursday, May 15, 1997, 3-6 PM, AIDS Office - 25 Van Ness Ave. 3rd Floor

(HPPC will meet from 3:00 to 4:00 PM and Committees will meet from 4:00 to 6:00 PM)

Tentative: May 22, 1997, 3-6 PM, First Unitarian Church - Franklin & Geary Streets

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HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for April 17, 1997

Please note in your calendar any of the following May meetings that apply to you:

Council Meetings:	♦ Thurs., May 8, 3-6pm at 1187 Franklin St. (at Geary Blvd.) ♦ Thurs., May 15, 3-4pm at the AIDS Office (25 Van Ness Ave.)
R.&R. Task Force:	♦ Tues., May 13, 2-5pm at the AIDS Office (25 Van Ness Ave.)
Committees:	♦ Thurs., May 15, 4-6pm at the AIDS Office (25 Van Ness Ave.)

Members Present:
Barbara Adler
Ronnie Ashley (Chata)
Ahimsa Timoteo Bodhrán
Gene Copello
Roberto Garcia
Kevin Gogin
Ellen Goldstein
Vic Hernandez
Liz Highleyman
Jelousy Jiggetts
Sacul L'Adnbre
Jennifer Lorvick
Askia Muhammad
John Newmeyer
Henry Ocampo
J. Colin Partridge
Dawn Passar
Joel Reyna
María Rinaldi
Bethsaida Ruiz
Steven Sams

Guests:
Michael Discepola, AHP/Strat. Eval. Committee
Cynthia Laird, B.A.R.
Dana Van Gorder, DPH
Stacy Vogan, HIV/STD Prev. Training Ctr.
David Weissman, filmmaker

Members Absent:
Isabel Auerbach
Jimmie Naritomi (out sick)
Sandy Simms

AIDS Office Staff:
Brian Dobrow
Delia Garcia
Valerie Kegebein
Tracey Packer
Mike Pendo
Billy Pick

Harder + Co./Polaris, Inc.:
Martin Forst, Polaris
Ellen Irie, Harder + Co.
Mary Irvine, Polaris
Steven LaFrance, Harder + Co.
Amalia Fernandez-Niewendorp, Polaris
Lyn Paleo, Harder + Co.

HPPC Process Evaluation Team:
Pali Basi
Ruel Caneda
Cathleen Farrell
Cely Queiroz
Kathleen Roe
Kevin Roe

1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Ellen convened the meeting, explaining that it would be the first time for the Council to try this arrangement of meeting for one hour and then breaking into separate committees, at the AIDS Office. She initiated the introductions, after which she gave the Council a quick review of the agenda. Speaking about the agenda item on prevention PSAs (public service announcements), she noted that this would serve as another opportunity for the Council to provide a sounding board and a central point for presenting information related to the work of HIV prevention.

2. GUEST PRESENTATION: PREVENTION PSAs

Introduction

Gene introduced the guest David Weissman, who would be showing prevention videos that he had made as PSAs. Gene referred members to the article (distributed at this meeting, enclosed for those absent) that was published in this day's issue of the B.A.R. (4/17/97). Gene went on to say that David Weissman had been nominated for a Northern California Emmy Award for his PSAs.

David said that he had made a series of eight prevention PSAs for HIV-negative gay men. They were funded by a variety of sources, but were independently produced, and David controlled their content. He referred to an article written by Dana Van Gorder (DPH coordinator of lesbian and gay health services) in the Sentinel, regarding the psychological stresses of the epidemic on gay men. Dana Van Gorder and David Weissman had spoken about ways to alter the dialogue around HIV/AIDS, and to address what was going on in the broader gay community. They agreed that there is a problem of silence around the difficult, underlying emotional issues which can significantly affect gay men's abilities to remain uninfected. Van Gorder and Weissman served together on an advisory committee for Michael Discepola's project at AHP.

David said that he had brought up the possibility of using television as a vehicle for reaching a broad and captive audience in a direct manner, with prevention messages addressing the psychological effects of the epidemic. With Dana Van Gorder's stamp of approval, he went to KRON-TV with a proposal for the PSAs. They made a three-month commitment to showing the prevention spots that David would develop. He then took the scripts to various agencies, where he presented his plan and found funding for it. David added that KGO-TV and Channel 7 had also decided to use the spots, giving them a long run and good visibility.

Video Presentation

At this point, David showed the eight PSAs to the Council. Each 30-second spot had a single person directly addressing the viewing audience. The characters delivering the prevention messages varied in age, race/ethnicity, gender, sexual orientation, HIV status, and self-positioning in relation to the HIV/AIDS epidemic (e.g., father of an HIV-negative adult gay son who has experienced the loss of some of his friends; female friend of a gay man; young HIV-negative gay man, young HIV-positive gay man; 50-year-old HIV-negative gay man in love; probably-heterosexual male high school student with a probably-gay male friend; etc.). At the end of each video, an agency logo and phone number appeared on the screen for a few seconds. The following agencies were represented in the eight spots:

- Stop AIDS Project (Q-Action);
- SFDPH;
- S.F. AIDS Foundation (twice);
- LYRIC Youth Hotline;
- PFLAG;
- Brothers Network; and
- AHP.

The characters shown in the videos discussed their concerns about safety (their own and their friends/loved ones), their feelings about the future, and their feelings about the experience of loss. They also gave expression to their love and support for gay men (or *other* gay men). Each spot offered a personal testimony to the issues raised by the epidemic.

Question and Answer Session

In response to a question about the production costs of the videos, David Weissman responded that he had raised $35,000 for the video project.

Dawn asked about the source of the scripts used, and David explained that he had written all of the scripts, but that two of the spots had been based on the specific, personal stories of the people who appeared in them.

Kevin Gogin asked about ways of obtaining the spots for use in the schools. David responded that either the California AIDS Clearinghouse or the CDC AIDS Clearinghouse would have longer versions of the PSAs, which they could distribute for education, training, and discussion purposes. David added that he was also working out ways to use the PSAs in other locales.

Sacul stated that she thought the spots were good, but she asked if they would become more diverse (representing Asian/Pacific Islander, Native American, and Latino populations). David Weissman asked Sacul if the content seemed racially-specific to her. Sacul explained that, looking at the particular people chosen to deliver the messages, the viewing audience might think that, for a given spot, the content was intended to be specific to people of the same ethnicity as the speaker. For that reason, she thought it would be helpful to have a greater variety of ethnic groups represented in the eight spots. David stated that, since he had only used one person for each spot, each spot could only appear as racially diverse as the person in it. He said that he had not cast the people in the video according to their respective ethnicities. He then answered his own question to Sacul, saying that the content of the PSAs was not in any way ethnically-specific.

Ahimsa expressed his sense that the PSAs could be more effective if they *were* more culturally-specific. He said that the scripting of all eight spots by one person (and a white person) was perceptible to him in listening to them. He explained that the scripts did not sound culturally-appropriate to some of the individuals reading them. David responded that this was the first time he had heard this criticism, and that he was interested to hear it.

Roberto asked if David had any plans to reproduce the spots in Spanish. David responded that he had carried out this project on his own, and had done the most he could with his capacity and his area of expertise. However, he said that he would be willing to talk with other people about possibilities for expanding on the PSAs, and about how they might want to fund that work.

Ellen said that she had found the PSAs to be very powerful and resonant. She noted that some of the spots will work for some people, while others will work for other people. David responded that the spots were designed to target different groups of people, and he added that they were all made with the idea that the HIV/AIDS agencies in San Francisco were not doing their job in this area. He said that the spots had first aired (on KRON-TV) last September.

John said that he thought David had done a good job at addressing high-risk groups and getting away from middle-class language and lifestyle assumptions. David noted that he had meant for the PSAs to be directed at gay men, but that he would be delighted to see someone else doing something similar for women and IDUs, for example. He explained that he had drawn upon his own strengths in creating the PSAs, and he told the Council that he had received a very positive response to them from people of all ethnicities.

Vic expressed appreciation for what David had produced, noting that he had never heard anyone talk in this way about the effects of loss on people's abilities to survive the epidemic -- and that it was gratifying to see a project addressing the issue. He encouraged David to get the PSAs out in circulation, on every channel, if possible. David responded that he had done this work as an individual, and that it was not his responsibility now to get the PSAs on more TV channels. He said that this responsibility should rest with the city and its prevention agencies and prevention planners. David said that he did not know of any HIV/AIDS agencies in San Francisco doing PSAs, and that he certainly hadn't heard of any making PSAs with the word "gay" in them. He added that only the S.F. AIDS Foundation had assisted him in bringing the spots to television; no other agencies had expressed any interest. He found it appalling that nobody in San Francisco had even asked to see the video spots until now, considering that they had begun to run on TV last fall.

Dawn responded to David's comments by explaining that different prevention agencies do their work in different ways, using different approaches and media -- depending on what is most likely to reach their specific populations. As an example, she said that her agency often uses picture books to present prevention messages. David replied that he did not mean to diminish those other kinds of efforts, in the process of venting his frustration at the city and the local prevention system.

María gave three comments in relation to David's presentation:

1) Regarding Sacul's comment and his response, she said that she agreed that the prevention message in each spot applies to more than just one community. However, she explained that information sometimes has to be presented in different, culturally-specific ways, and in different languages -- in order to reach everyone for whom it is intended.

2) She noted that, unfortunately, most agencies in this city do not receive any funding for media, and that the San Francisco AIDS Foundation (from which David had received support) is one of the few that does receive this kind of funding.

3) She asked to know what kind of decision-making had gone into the use of a particular agency logo after a particular PSA. {David explained that he had independently chosen to use some of the logos (with the agreement of the agencies) in places, and that some of the usage of logos was determined by funding.}

David reiterated that he had had a specific target audience (HIV-negative gay men), and that the amount of diversity that he could achieve in eight spots was limited. He added that a Hawaiian AIDS organization had liked the diversity of the imagery in the PSAs, and had asked to use them. He said again that he would love to see these spots done in a variety of different ways and in different languages.

Ahimsa offered three comments:

1) He said that a number of visual PSAs are going on now, although they might not necessarily be on video. He noted that Proyecto Contra SIDA Por Vida had put together a PSA addressing a specifically queer, Latino audience.

2) Regarding the logos appearing at the end of the spots, he said that a lot of the agencies represented had become more lesbian/bisexual/transgender-inclusive than they were in the past. He felt that it would be important to represent these agencies and their logos in their own, current terms. {David responded that the agencies had provided their own logos.}

3) He said that, while it is important to recognize anger and frustration, he felt disrespected by some of David's reaction to feedback offered by Council members. He suggested that David refrain from pitting the feedback of one community of color against that of another, in order to deflect criticism.

Ellen spoke up to acknowledge the amount of effort that David Weissman had put in as an individual (not for pay, and without the guidance and support of an agency) for the good of the community. She said that (1) the Council should respect this kind of volunteer work, and (2) that the Council may or may not agree with the material that people bring to share with this body, and that it is important for members to be able to acknowledge and express their feelings and opinions. In closing, she said that it is always better to have more hands involved in the effort of prevention, and that the enemy is not other people working on the epidemic -- but the epidemic itself.

David closed by saying that this project has been an eye-opening experience for him in many ways, some of which are gratifying, and others of which are bewildering and disheartening. He said that he had learned of some of the complications in the HIV/AIDS prevention community. He added that he would encourage people to detach themselves a little from their agendas, in order to see the larger world around them.

3. CDC SUPPLEMENTAL DISCUSSION: OPTIONS

Background

Ellen informed the committee that the Supplemental Funding Task Force, charged with coming up with some criteria and helping to focus the conversation around this new piece of resource allocation, had met on April 14th. The group received information from the AIDS Office at that meeting, and produced a preliminary draft of options for the Council.

By way of background information, Ellen explained that the CDC Supplementary funding is awarded according to a formula, and that each jurisdiction can then apply for the piece allotted to it. Ellen explained that it is the responsibility of the Planning Council to form recommendations for the use of the Supplemental funding, and to work in partnership with the AIDS Office to determine the substance of the proposal to be sent to the CDC. After reviewing the proposal written by AIDS Office staff, the HPPC writes an accompanying letter of concurrence (agreement) or non-concurrence (disagreement). The CDC will not actually award the Supplemental funding to a jurisdiction unless the grant proposal is accepted.

Handout with Breakdowns of Local Prevention Funding by Ethnicity of Groups Served

In order to answer some of the questions raised at the April 10th Council discussion of the Resource Inventory summary chart, the AIDS Office staff supporting the Supplemental Funding Task Force worked out an ethnically-specific breakdown of funding. Ellen distributed a handout (enclosed for those absent) showing estimates for the AIDS Office funding allocations (p. 1), the CDC direct funding allocations (p. 2), and the combined San Francisco funding allocations (p. 3) -- by BRP and ethnicity. Gene took a moment to acknowledge the fast work of the AIDS Office prevention staff (and especially of Mike Pendo) in pulling the resource inventory charts together.

Ellen explained that the chart with AIDS Office funding percentages reflects the proportions in which the funded agencies expect to serve clients, combined in some cases with the proportions in which they served clients in the previous year (if the contract for this year is similar).

The chart with CDC direct funding was explained as not yet final, since the direct-funded contracts had not yet been awarded. The CDC was planning site visits to a set of the applicants, and the chart reflects the proportions in which those applicants proposed/expected to serve clients, should they receive the amounts of funding they had requested in their applications. Ellen explained that this piece of the information was new, and had not even been available at the Task Force meeting on Monday. She said that the Task Force members would work with it further at their next meeting. As a result of (1) the unavailability of final information on the CDC direct-funded contracts, and (2) the ongoing contract negotiations for some of the AIDS Office-funded agencies -- the information on the third page of the handout is also a rough estimate at this point.

Discussion -- Ethnicity Breakdown Charts

Chata asked what would fall under the "other" category for ethnicity in the charts. Mike Pendo responded that it would depend on the particular agency's use of the term in its forms. He did not feel comfortable generalizing about the usage of the term across agencies. Barbara added that, for counseling and testing, "other" is used as the category for any ethnic identification that does not fall into the 15 specific categories. For example, it would be used for someone identifying as bi-racial. John Newmeyer added that, for HAFC, about two-thirds of the people in the "other" category are bi-racial or multi-racial. Ellen noted that the problem of a lack of specificity and comparability in client data was being addressed in the behavioral risk assessment (BRA) -- which includes columns allowing a client to identify with one or two ethnicities, and to have both counted.

Handout with Options for Supplemental Funding

Ellen then presented a second Supplemental Funding Task Force handout (enclosed for those absent), which presents options for how to use the additional funds. She explained that feedback from the Council, the Task Force and the AIDS Office was being incorporated into this document. Ellen then read through the 13 options listed in the draft document. She invited Council members to add more options to the list, and she added that none of the options are intended as "either/or" decision-making items. She noted that the Task Force would continue to work on prioritizing and setting criteria, and would bring back refined drafts to the Council.

Discussion -- Draft of Options, and Other Data Still Needed for Decision-Making

María, a member of the working group, stated that some of the options listed could also be seen as including others (umbrella options and specific options). She also asked about whether the Council could use the chart format that includes a breakdown of funding by intervention type (such as the one mailed prior to the April 10th meeting). She explained that she was concerned that too much funding from RFPs #015 and #016 had gone toward CTRPN (counseling, testing, referral, and partner notification). As an example of what this could mean for the gaps in service, she pointed out that -- while the total number of programs serving FSM was shown as 15 -- seven of the 15 were CTRPN, while only eight covered other prevention activities. She expressed her sense that CTRPN is different from other prevention activities, in that it is not necessarily an intervention that specifically serves those who are uninfected. Ellen responded that the question of distribution of funding by intervention would be more closely examined by the Supplemental Funding Task Force in its next meeting.

Steven added a note to the Council members that some of the options mentioned at the previous Council meeting had not remained on the list, as a result of information on the limitations on uses for this CDC money (e.g., a prevention planning summit could not be funded with it).

Barbara said that the charts and the "options" document offer a lot of information in a succinct manner, which will be extremely helpful for decision-making on the Supplemental funding.

4. BREAK
Following the break, Council and community members, staff, and consultants broke up into small groups for their committee meetings.

Enclosed with These Minutes (for those absent):

- B.A.R. article on David Weissman's prevention PSAs
- Funding charts by BRP and ethnicity
- "Options for Supplemental Funding" draft document
- "Evaluation Results" and "Participant Dialogue" from 4/10/97

Minutes Recorded by: Mary Irvine
Minutes Approved by: Community Co-Chairs Ellen Goldstein and Chata, and AO Co-Chair Gene Copello

HIV PREVENTION PLANNING COUNCIL MEETING

May 8, 1997
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Gene Copello
Ellen Goldstein
Ronnie Ashley (Chata)

Please read: **Agenda and minutes of April 10 & 17, 1997**
***Please bring*:** **Minutes and Agenda**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Food/Welcome/Introductions/Announcements	Gene Copello	3:00 - 3:15 PM
2. Public Comment	Chata	3:15 - 3:35 PM
3. Minutes from April 10th & 17th	Gene Copello	3:35 - 3:40 PM
4. Supplemental Options Discussion & Concept Vote	Chata	3:40 - 4:40 PM
5. Break		4:40 - 4:50 PM
6. Membership Committee: ByLaws Changes	Jelousy Jiggetts	4:50 - 5:15 PM
7. Process Evaluation Report	Kathleen Roe	5:15 - 5:25 PM
8. Committee Updates	Chairs	5:25 - 5:55 PM
9. Closure/Evaluation	Kathleen Roe	5:55 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC & Committee Meetings - Thursday, May 15, 1997, 3-6 PM, AIDS Office (3rd Floor) 25 Van Ness Ave.

(HPPC will meet from 3:00 to 4:00 PM and Committees will meet from 4:00 to 6:00 PM)

HPPC Meeting - Thursday, June 12, 1997, 3-6 PM, First Unitarian Church 1187 Franklin Street (@ Geary)

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HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for May 8, 1997

***Please note in your calendar any of the following meeting times that apply to you: ***

Council Meeting:	♦ Thurs., May 22nd, 3-6pm @ 1187 Franklin St.
Roles & Responsibilities T. F.:	♦ Tues., June 3rd, 2-5pm @ AIDS Office
Linkages Committee:	♦ Thurs., June 5th, 10am-noon @ AIDS Office
Assessment Committe:	♦ Thurs., June 5th, 3-5pm @ AIDS Office

Members Present:
Ronnie (Chata) Ashley
Isabel Auerbach
Ahimsa T. Bodhrán
Gene Copello
Kevin Gogin
Liz Highleyman
Jelousy Jiggetts
Sacul L'Adnbre
Askia Muhammad
Jimmie Naritomi
John Newmeyer
Henry Ocampo
Dawn Passar
Joel Reyna
María Rinaldi
Bethsaida Ruiz
Steven Sams
Sandy Simms

Members Absent:
Barbara Adler
Roberto Garcia
Ellen Goldstein
Vic Hernandez
Jennifer Lorvick
J. Colin Partridge

Harder + Co./Polaris, Inc.:
Amalia Fernandez-Niewendorp, Polaris
Martin Forst, Polaris
Mary Irvine, Polaris
Steven LaFrance, Harder + Co.
Lyn Palco, Harder + Co.

HPPC Process Evaluation Team:
Pali Basi
Ruel Caneda
Cathleen Farrell
Cely Queiroz
Kathleen Roe (and her son, Cameron)
Kevin Roe

AIDS Office Staff:
Brian Dobrow
Delia Garcia
Marshia Herring
Valerie Kegebein
Michelle Long-Dixon
Tracey Packer

Guests:
Mike Discepola, AHP
Cynthia Laird, B.A.R.
Hank Wilson, ACT UP G.G.
Craig Yee, HIV Contractors Assc.

1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Gene convened the meeting shortly after 3:00 p.m. He invited the members present to take food and drinks from the table. Then he began the introductions with an exercise in which everyone was asked to say their name and what outdoor activities they had or would like to have participated in.

Announcements:

Gene -- Notification of Resignation

- Gene Copello informed the Council members present that this would be his last day as DPH co-chair of the HPPC. He has recently accepted a position at a CBO in Jacksonville, Florida. He will also be teaching at the University of Florida. His last day at the AIDS Office will be next Friday, May 16th. He is excited, but sad to be leaving his good friends and co-workers. He wishes the Council the best in its work. He feels that it has been both a creative and extraordinary experience to work with all of the members in what has become a national model for prevention planning. He informed the members present that Tracey Packer will be the interim DPH co-chair starting at the end of this meeting. She will serve in this position at least until a new branch director is hired. He assured the

members that the new director will also be very involved with the HPPC, and gave his best wishes to Tracey.

Steven -- Notification of Free Tickets for Shanti Reunion

- Steven Sams offered 4 free tickets to the Shanti Reunion that would take place on Saturday, May 10th. It would be a 40's-style dinner & dancing event. It was planned as a reunion in honor of care providers & volunteers.

Lyn -- Second Consensus Meeting

- Lyn mentioned that on Monday, May 12th, the AIDS Office Seroepidemiology & Surveillance Branch would be hosting the 2nd Consensus Meeting. The first meeting, held in 1991, resulted in a 1992 report which was utilized for the estimates found in the current Plan. John Newmeyer will be attending and presenting as a representative member of the HPPC, as well as a researcher. There will be approximately 40 researchers updating the seroprevalence, population size and incidence estimates. It is an invitation-only meeting that will have its results issued in a report.

Ahimsa -- Notification of Resignation

- Ahimsa informed the members present that this would be his last meeting. The main reason for his resignation is economic. For the last several months, he has been living in poverty; and participation in the HPPC, however important, has created an additional financial burden (i.e. volunteered time, transportation, etc.). He mentioned that lack of available time was another reason for his resignation. Between his 3 jobs, his pursuit of a BA in Women's Studies, his book-writing, and his activism, he does not have time to participate in the HPPC. He expressed his appreciation of having been able to work on the Council. He also extended a challenge to the HPPC, to evaluate how they could make the participation of youth and low-income people in the HPPC more accessible. He thanked Chata, Ellen, Mary, and Kathleen Roe and her evaluation team, for being so helpful over the last few months. He also thanked all HPPC members and Joshua Volle. He finished with a request that the members of the HPPC remember that they are the 'work' -- taking care of themselves and their communities is what is most important in their endeavor to stop the spread of HIV.

  Chata offered his gratitude and extended best wishes for Ahimsa's future. He also left Ahimsa with an invitation to return, if and when time would allow him. He then thanked Gene for serving as DPH co-chair. He admitted he was surprised to hear of Gene's resignation, but welcomed Tracey Packer into her interim position as co-chair. He mentioned that she would be bringing with her the experience and leadership of 4 years in the planning process, including her past participation in the Linkages Committee.

Chata -- Notification of Member Absences

- Chata mentioned that Ellen Goldstein was absent due to her vacation in Greece. He also mentioned that Barbara Adler had called him earlier to inform him she would not be able to attend today's meeting.

Chata - Committee Reports

- Chata mentioned that the Roles and Responsibilities Task Force members recently met to take care of revisions on sections of their document in progress. They are waiting to finish

the resource allocation piece, before they make a presentation to the full Council. The Roles and Responsibilities Task Force has been working on the document for about six (6) months, and although the process is difficult, the group is generating decisions and the full Council will be notified of them once they are made.

Chata also mentioned that the Steering Committee met on May 5th to discuss the procedures involved for new community membership within the committees. Membership forms would be made available to committees at the May 15th meeting. He also mentioned that the Steering Committee spent some time talking about committee facilitation, chairing, agendas, etc.

Chata spoke about a decision made at the Steering Committee meeting for the future one-hour Council meetings (the 3rd Thursday of every month). These open discussion meetings, or "open-mike" sessions, require that the co-chairs develop an agenda for them. To facilitate the agenda-setting process, the co-chairs are requesting that anyone who is interested in presenting to the Council, inclusive of any Council members or guests, must notify the co-chairs in advance to be placed on a list for consideration.

Valerie wanted to reiterate the process of inviting community members into the committees. Interested individuals must first fill out the New Community Member Form and then submit it to the AIDS Office. Once the AIDS Office staff have received this form, they will forward it to the co-chairs, who will review and discuss it, and then bring it to the committee chairs. The co-chairs will also send the new members a welcome letter.

Valerie also mentioned that, with Gene leaving, the DPH is looking again at re-structuring the Health Services & Prevention Branch. Organizational charts will continue to change. Currently, the DPH is looking at separating health services from prevention/health promotion. Logistically and functionally, the DPH will not change; but there may be some organizational effects. The communication between units and branches, for instance, will be a challenge to be addressed in the reorganization.

Kathleen - Evaluation Sheets

Kathleen gave a quick explanation of the evaluation sheets distributed today. The summary of results from the April 17th Council meeting and a "Community Outreach Form" are enclosed for absent members (see Attachment 1).

Gene - Community Planning Leadership and Orientation Training

Gene distributed the Brochure for the Community Planning Leadership and Orientation Trainings, sponsored by the National Minority AIDS Council and the National Native American AIDS Prevention Center. A brochure is enclosed in these minutes for absent members (see Attachment 2).

2. PUBLIC COMMENT

Chata informed the group that anyone interested in Public Comment needed to sign up and to limit their presentations to 3 minutes each. There was only one person to comment at this meeting.

Post-Exposure Prophylaxis: *Hank Wilson, ACT UP Golden Gate.*

Hank addressed the issue of Post-Exposure Prophylaxis (PEP). He mentioned two specific groups that are currently involved in the dialogue about PEP: one is the Community Advisory Board

(which is meeting with Dr. Katz of the AIDS Office), and the other is the UCSF Project Options, at San Francisco General Hospital. Hank mentioned that many of the issues which were not made clear when Dr. Katz made his presentation on PEP to the HPPC are being ironed out in these meetings through an open process. He mentioned that it seemed to him that not all communities were being represented at these meetings. He wanted to point out the implications of PEP for youth and low-income people who are currently not able to access state-of-the-art medications and treatments. Many questions remain to be answered (e.g. If someone fails with PEP, can they try again in two months? If they fail three times, can they try it again? What are the limits?) The model for PEP use is being created in the course of these meetings; therefore community input is essential. He mentioned implications for the prevention efforts that are being done in the community. Once people understand that PEP is available, will it affect the commitment to safe behaviors? What is the city's commitment to PEP, and how much is going to happen? Should they make it obvious that they are still in research mode, so as not to give the impression that PEP is widely available? Hank left the Council to consider these questions.

Hank also mentioned that the CARE Council is in the process of developing a grievance policy regarding their funding allocations. It has been initiated by people with AIDS within the CARE Council. He stated that, if the HPPC does not have a grievance policy, they should look into initiating one, due to the dissatisfaction with the last process. (Note: The Roles and Responsibilities Task Force is working on recommendations for a grievance policy.)

In terms of the DPH research agenda, Hank said that there needs to be a regular report to someone other than the DPH. He explained that the HPPC needs to keep abreast of what is being done in research, and to take an interest in where the research dollars going, and whether research is being conducted in accordance with the HPPC Plan or any plan. Since there is no longer a Epidemiology/Research Committee, Hank feels that there is now a vacuum.

Tracey mentioned that there would be a forum on PEP on Friday, May 9th, from 3 p.m. to 5 p.m. with Dr. Katz, as well as a meeting with the Community Advisory Board and Dr. Katz at the AIDS Office on Wednesday, May 14th, 5:30 - 7:30 p.m..

3. APPROVAL OF MINUTES FROM APRIL 10, 1997 & APRIL 17, 1997

Mary made mention of the following corrections to the 4/10/97 minutes: Dr. Katz should be under AIDS Office Staff, and Amalia Fernandez-Niewendorp should be with Polaris.

With a quorum present, the minutes of 4/10/97 were approved by consensus.

With a quorum present, the minutes of 4/17/97 were approved by consensus.
(Jimmie Naritomi abstained, due to his absence).

4. CDC SUPPLEMENTAL DISCUSSION

Chata invited Valerie to join him in presenting the revised Supplemental funding options. He mentioned that, since the initial handout of 13 possible options, the Supplemental Funding Task Force (SFTF) had convened and combined some of the original options to narrow the list down to 7 options (see Attachment 3).

Brian mentioned that these 7 new options would be put to a concept vote at this meeting. Chata reiterated this and then introduced Lyn to clarify what was meant by a concept vote.

Lyn clarified that the idea of a concept vote was instituted last year. It is a preliminary vote that indicates if whether the general approach is acceptable to the Council, though all the details have yet to be finalized. After this concept vote, the SFTF will incorporate any changes, defining and refining all the details, for the final product vote.

Maria asked for clarification on whether the Council's approval of a general approach with a concept vote means that whatever happens next will happen within that framework. Both Chata and Valerie responded that the final vote would be in a similar framework. Valerie then went on to present the draft of the Options for Supplemental Funding, CDC Cooperative Agreement 1997. She mentioned that the SFTF members are listed on page 4, and that these members have been participating on this task force on behalf of the Council.

- **Option # 1:** This option addresses the unmet needs within the city. There is still a need to review the 'Criteria' and the 'Other Needs' boxes, before the final recommendations are submitted to the Council.

- **Option # 2:** This option again addresses unmet needs. However, these unmet needs can be easily identified as relating to programs that are losing direct funding from the CDC. The AIDS Office and DPH are currently putting together charts about these programs, to assist the Council in making the final decisions.

- **Option # 3:** This option is for a comprehensive PEP component. It will include a training endeavor, a media endeavor and perhaps a counseling endeavor. It will require 1 FTE prevention counselor. The cost of this particular option will be shared with the following Option 4.

- **Option # 4:** This option will serve as an enhancement to the previous option of funding an individual to do linkages between HIV/STD training and prevention counseling. The cost will be shared with the above option.

- **Option # 5:** This option again deals with unmet needs. It will assess current resources to female partners of IDUs. A cost-free needs assessment will determine who the current providers are actually serving at their agencies (in terms of women that fit into this profile).

- **Option # 6:** This option will fund DPH laboratory costs for CTRPN. Since funding will be lost due to changes in State policy for reimbursement, laboratories might not be able to continue running HIV tests without additional funding, which would mean that fewer tests could be provided.

- **Option # 7:** This option will target Young MSMs who use speed, based on the SFTF's identification of prevention for young MSMs using speed as a prioritized unmet need.

Supplemental Discussion Questions and Answers:
John mentioned how timely it was to be discussing this information, since the Consensus meeting would take place on Monday, May 12th. He volunteered to report to the SFTF about the results of the Consensus meeting, to clarify the Council's thinking on what groups are at risk. He said he felt this would enable the SFTF to compare high-risk populations with those receiving services in the current resource inventory.

The co-chairs present both agreed that this would indeed be helpful. Steven recommended that John should make a presentation to the SFTF at their next meeting on the morning of May 15th, from 9:30 a.m. to 12:30 p.m., at the AIDS Office. John agreed that he would try.

Lyn mentioned that many of the researchers had made it clear that they were concerned about confidentiality and the pre-release of results from their as-yet-unpublished research. Because of their concerns, they were promised that the information from this Consensus meeting would not be released until the final report (which they will be able to proof, edit and approve before its release). Steven asked if it might be feasible to get some generic information from the meeting. Valerie interjected that perhaps Lyn could talk with Willi McFarland of the AIDS Office (the organizer of the Consensus Meeting), to see whether he would agree to present or have John Newmeyer present to the Council on results of the Consensus meeting. Perhaps they could offer some preliminary research results, which the HPPC would use for the sole purpose of facilitating its decisions about the Supplemental funding. Jimmie mentioned that this Consensus meeting information could also be beneficial to the Assessment Committee process.

Jimmie then asked for clarification on Option 5. Although he has no opposition to this option, he wanted to know why there was no mention of male partners of IDUs. Both Steven and Liz responded that this specific group, females partners of IDUs, falls nowhere in the BRPs 1-12 now, because the BRPs are based on risk behavior, not risky partners. Jimmie mentioned that it seems that there are others in BRPs 9-12 who lack services, and they are not all women. He said that there is nothing wrong with Option 5, but that it seems to leave out others at higher risk because of their partners' behaviors.

Dawn mentioned another gap that needed to be addressed: women working in strip joints throughout San Francisco. She reported that generally outreach workers can't go into strip joints. While she noted that the Women's Program under the Exotic Dancer's Alliance serves these women, she proposed that a study be done with this underserved population. Maria responded to Dawn by pointing out that what she was talking about fits under Option 1, "Fund unmet needs among women..." -- but she said, since Dawn had mentioned it, the SFTF would remember to look at this particular gap. She also mentioned that not everyone on the SFTF thinks all of these options should be funded; the SFTF members had not voted yet.

Jelousy reiterated the notion of the Council members giving SFTF more specific ideas. He explained that the task force wanted to get a broader picture, which would require more input and comments on specific unmet needs gaps from Council members.

Bethsaida asked for clarification of Options 3 & 4 -- specifically on whether both options could be funded at the same time, with same amount of funding. Steven responded that they both could; but, if it was funding an existing program, it would cost more. Valerie mentioned that, if they did not include the STD piece, they would not get the full amount from DPH. It would be more cost-effective to fund both options, since the hiring of one FTE would cover the activities under both.

Steven mentioned that the SFTF had failed to underscore in the presentation that Options 5 & 7 are the kinds of specifics that came out of the last couple of Council meetings. They also fall under Option 1, and were identified early on as major gaps in services.

Liz had 2 questions:

1. Regarding Option 4, how did the STD piece go from STD Treatment and Education to Education only?

2. For Option 2, is there specific information on which programs might be losing direct funding from the CDC?

Valerie responded to both questions:

1. The AIDS Office cannot fund treatment with prevention dollars, but it can enhance an educational piece among prevention providers.

2. At the last notice from CDC, programs which will not continue to receive direct funding include: SFAF Compass Project, Iris, JCYC, NTFAP, and CSEARR. The AIDS Office also can make available a chart of previous funding. (Update from Tracey: There is now information available to indicate that CDC Direct-funded programs will include STOP AIDS Project, MNHC, and API Wellness Center. It has also been confirmed that TARC will not receive CDC Direct funding.)

Maria wanted to know if Option 2 would involve funding programs for specific agencies, or just funding particular target population and services. Valerie responded that the draft is referring to the services, not necessarily the same agencies.

Steven asked if it had yet been determined if any of those agencies de-funded by the CDC had failed to submit a request. Valerie explained that Steven was getting into finer points, and added that the CDC had not yet made final decisions. Steven said that, once the CDC's final decisions are made, the SFTF needs to review the overlaps and gaps for populations and interventions.

Liz wanted to know if the CDC decisions would be available before the Council had to make its final decision on the Supplemental funding. Valerie replied that she hoped that they would, but there was no definite answer at this time. Jimmie mentioned that the list offered by Valerie simply includes those who weren't finalists for CDC Direct funding. Those not funded would constitute a bigger gap. Also, the CDC had less funding to allocate this time. Valerie assured the Council that the SFTF is receiving all of the available data and checking the inventory of services before making recommendations.

Chata then presented the financial caps (limits) identified by SFTF for Options 3, 4 and 6, and a minimum amount for Options 1, 2, 5, and 7*:

- **Options 3 & 4:** $ 120,000.00 (maximum)
- **Option 6:** $ 121,181.00 (maximum)
- **Options 1, 2, 5, & 7:** $ 477,924.00 (minimum)

* The actual costs will be determined after the SFTF looks at specific unmet needs and gaps.

Henry asked if Option 6 included oral HIV testing. Tracey responded that it was inclusive of oral testing, since it is the same in cost and structure as blood testing.

Valerie added that -- if the SFTF determines that more is needed to cover the unmet needs under 1, 2, 5, & 7 -- the members can and will revisit the amounts considered for Options 3 & 4 and Option 6. She reiterated that none of the presented information is final.

Liz wanted clarification on whether Options 3 & 4 require two AIDS Office staff or just one AIDS Office staffperson. Valerie confirmed that Options 3 & 4 require only one staffperson.

Concept Vote:
Brian then asked the Council members if they were ready for the concept vote: to accept the current general approach of the SFTF draft. There was no opposition or disagreement. He then requested that someone begin by making a motion to accept the draft work in concept. Sacul made the motion, and it was seconded.

In favor:	16
Opposed:	0
Abstentions:	0

Consensus was achieved, and the motion to approve in concept was passed.

Brian made mention that the next SFTF meeting was scheduled for Thursday morning, May 15th. The group hoped to go over all the details and to present to the Council that same afternoon. If this could not happen, a special meeting would be set. (They can't defer to the June 12th meeting, because it would be too late for the application process.)

Chata mentioned that he would have an answer on a possible meeting for the 22nd of May by the end of the day, after he conferred with Tracey Packer. (Update: There will be an HPPC meeting at the First Unitarian Church on May 22nd, from 3-6pm, to vote on the SFTF recommendations.)

Liz requested that further discussion be initiated to determine the overall feeling of the Council members regarding the options (e.g., should they go with all or some?). The SFTF would need the opportunity to hear more input from the Council. Jelousy mentioned that perhaps the members could give the information to the co-chairs. Chata agreed and mentioned that members could also utilize the space in the evaluation sheets. He also mentioned the possibility of discussing this issue at this time, if the agenda allowed it. Maria reiterated the comments of the SFTF members Liz, Jelousy and Chata. She wanted more input from the Council. Specifically, she wanted to know whether members were in agreement or disagreement with what SFTF had included in the draft Options document. Steven reminded the members that this information was required in a timely manner, due to the CDC application deadline. Brian mentioned that the application would be brought to the Council by the June 12th meeting for a final vote. At that time, a letter of consensus would be sought. Liz mentioned that it would be helpful to see how people rank the general importance of the options.

Sacul asked whether the funds would be distributed in some direct manner or through RFPs. Valerie responded that the task force might decide to RFP some of the money and sole-source some of it. The SFTF had yet to reach that point. There seemed to be different options for getting the money into organizations/programs; however, this had not yet been determined.

Steven mentioned that the SFTF had discussed the idea that all planning work has to be about empowering the agencies delivering the services. The SFTF goal/priority is to facilitate their

prevention efforts. The SFTF also discussed the interesting kinds of partnerships that might be developed (e.g., with PEP, the HPPC could get corporate money to translate and provide information in other languages).

Jimmie mentioned that he had missed the last meeting, and therefore he had a question about the new charts with the breakdown of services by ethnic/racial groups. He was unclear about the 85% for API under CDC Direct funding. He would like to see more details, in order to be able to identify real gaps. He said that he understood that the Council must get through this process by May, so he recommended that the SFTF sit down and make recommendations on priorities they find, based on information to which they have access. He also mentioned the difficulty of trying to determine the CDC Direct awards at this time. He recommended that the SFTF not focus on agencies, but look at gaps in BRPs and interventions. Valerie noted that the SFTF had already decided to approach this task in that manner.

5. BREAK

6. MEMBERSHIP COMMITTEE: BYLAWS CHANGES

Chata introduced Jelousy for a presentation from the Membership Committee, regarding the proposed changes to the Bylaws. These proposed changes were a result of the February 13th HPPC meeting. Although some of the AIDS Office titles will again be changing in the future, due to the re-structuring, Chata requested that those non-content-oriented word changes be made as they occur, and not be addressed today.

Jelousy referred to the proposed revisions that were mailed out, with the changes indicated by underlined and italicized text. He read each article, and Brian explained the changes.

Article IV - NOMINATIONS, Section 1. Changes:

1. Changed from "Director" to "Chief".
2. Deleted sentence on ex-officio status of Branch Chief (a redundant category now).

Motion to accept changes, seconded. Adopted/Approved by consensus.

Article IV - NOMINATIONS, Section 4. Changes:

1. Reduced number of positions (for persons affected by and infected with HIV) from 12 to 10. (The total now equals 37, not 39 -- in keeping with the recommendation of Steven Sams at a previous Council meeting.)

Motion to accept changes, seconded. Adopted/Approved by consensus.

Article V - APPOINTMENT, Section 1. Changes:

1. Changed names of AIDS Office units. (NOTE: These may change again in the future.)

Correction mentioned at this meeting: "...People of Color AIDS Advisory Committee" (PCAAC).

At this time, Jimmie motioned for an amendment -- to remove mention of the chief of the Programs & Policy Branch. Brian/Gene both mentioned that nothing had yet been clearly determined regarding a future chief, so it would be premature to make those changes today.

Chata recommended that the Membership Committee re-visit this specific article, since currently the HPPC co-chairs are not a part of the selection committees for the PCAAC or the Mayor's HIV Health Services Planning Council. Since the HPPC is not part of their selection committees, there is some question as to whether they need to be a part of the HPPC Selection Committee, or whether the HPPC should become involved in theirs. Brian explained that this question would have to go back to the Membership Committee for a full discussion at a later date, since it would require a separate amendment from the vote the Council was considering. He reiterated the changes, and requested authorization to make the relevant revisions to titles, units, etc. as they come up in the process of re-structuring. Maria interjected that the PCAAC doesn't have a committee to select chairs or members; she claimed that theirs is a more democratic process. (Clarification from Tracey: The PCAAC membership process does not use any procedure for selection or election, but allows anyone interested to join.)

Motion to accept changes, seconded. Adopted/Approved by consensus.

Article V - APPOINTMENT, Section 3. Changes:

1. Eliminated excess verbiage, since the appointment process is explained in Article V, Section 1.

Motion to accept changes, seconded. Adopted/Approved by consensus.

Article VI - OPERATING PROCEDURES, Section 1. Changes:

1. Changed to "... AIDS Office staff member with HIV prevention community planning and policy responsibilities and experience ..."
2. Changed to "... elected ..." (from "selected")
3. Changed language, as recommended at the February HPPC meeting, "By January 31st .... gender balance."

Joel asked for clarification as to whether the director of the AIDS Office has always had purview over the appointment of the DPH co-chair. Chata responded in the affirmative, and Brian mentioned that this may change in the future, along with changes to that title, due to DPH re-structuring.

Ahimsa asked if it was possible to change the language to "...gender *and racial* balance," when talking about election of co-chairs. He was not sure of the actual procedure for requesting the change, but he felt the Council should consider it. Brian stated that it was a reasonable request, but that the Membership Committee would have to discuss the issue further before bringing back a revision to the Council. This change would constitute a new amendment. Steven assured Ahimsa that the Membership Committee would discuss these recommendations at their next meeting.

Motion to accept changes, seconded. Adopted/Approved by consensus.

Article VI - OPERATING PROCEDURES, Section 2. Changes:

1. This section has been completely changed. The original section 2 was deleted and replaced with information regarding the term endings, mentorship, etc.

Jimmie had a question about the DPH co-chair time frame for voting after becoming an ex-officio: If the new appointment takes time, how long can the old DPH co-chair vote? Gene responded that, when there are 2 DPH co-chairs present, only one should vote. Valerie thought that, as an ex-officio member, Gene had had voting privileges. Gene clarified that the amendment to make the branch chief an ex-officio member came before he was appointed to the co-chair position, which eliminated the applicability of the ex-officio position. Valerie recommended that it should be specified that the former DPH co-chair can serve as an ex-officio Council member. {Note from Chata: The status of Gene Copello as an ex-officio HPPC member was originally proposed to involve the Prevention Branch chief in the HPPC process. The current co-chairs and Membership Committee have yet to discuss the more general possibility of having the former DPH co-chair serve in an ex-officio Council position. Chata recognized Valerie at this meeting so that she could offer clarification, but she was not officially recognized for other (recommendation-oriented) comments.}

Brian proposed a removal of the phrase, "... with full voting privileges ...". Steven clarified that this last change would be a correction, not an amendment.

Joel asked whether a person elected to fill in for a resigning co-chair can still fill a full term. Steven responded in the affirmative, and added that it is possible that they would fill more than one full term, through March. Liz added that this person would have to stand for co-chair election again at the opening of the new term. Brian mentioned that the Membership Committee had discussed the dates for election of the community co-chair. It can occur before terms end, in November or December, perhaps.

Joel then asked if the AIDS Office co-chair has an indefinite term. Brian responded that the term lasts until the co-chair is replaced by the appointing person, whoever that will be in the DPH. Only community co-chair and member positions are finite. Chata said that he was not aware of this difference in co-chair terms, and requested that the Membership Committee consider setting a 2-year term limit per election. Lyn mentioned that the appointment is in the DPH purview, not in the Council's. Chata wanted to know if the Council could recommend the terms, but not the person. Brian explained that the appointment is specified and chosen using the CDC Guidance. The HPPC can recommend, but cannot change this particular item (DPH term), as it reads in the Bylaws. Maria asked if this meant that there were limits to what the Council could and couldn't change in the Bylaws. Brian emphasized that the Council is authorized to change anything in the Bylaws that relates to the operations of the HPPC. However, the Council may not make changes to the Bylaws regarding the appointment of the DPH co-chair or State Office Representative, because of the mandate in the CDC Guidance.

Maria asked two questions:

1. Regarding the Selection Committee, does final approval of Council members come from outside this Council?

2. Can the Membership Committee bring in a list of all in the Bylaws that are not under HPPC purview?

Valerie responded to Maria's questions:

1. Yes. The Membership Selection Committee is composed of the chairs of local task forces and planning bodies, and can change based on changes in those bodies.

2. The Roles & Responsibilities document is outlining all purviews, including those related to the Bylaws.

Steven attempted to clarify the issue in simple terms. He compared it to the Constitution. The Council can do anything with the Bylaws, as long as it fits within the CDC Guidelines. As for the Selection Committee, it can't bypass the selection pool. That is within HPPC purview. Bethsaida asked where the CDC Guidance could be found. Valerie mentioned that the CDC Guidance could be found in the Plan, as well as in the Orientation binder.

Brian brought the Council back to the vote at hand, on Section 2. Tracey mentioned that, in light of the DPH re-structuring, the title of AIDS Office co-chair should be changed to DPH co-chair (since the AIDS Office may no longer exist as such). Brian agreed to make all of the title changes.

Motion to accept changes, seconded. Adopted/Approved by consensus.

7. HPPC PROCESS EVALUATION REPORT

Kathleen stated that the process she had witnessed at this meeting was a very important turning point for this Council, and she felt obliged to make mention of it.

DPH Co-Chair Resignation

She noted that, looking back at the last DPH co-chair transition, it had been a rather difficult experience for the Council. It was an unpleasant moment of public process that left many members feeling unhappy and uneasy about speaking their minds. This was reflected in the conversations, evaluation forms, dialogue boxes, etc. However, the events she witnessed at this meeting seemed to her to depict a process that has improved. She mentioned that the minute the rumors began regarding Gene's resignation, the co-chairs (with Chata strongly representing the Council) met with Mitch Katz regarding interim provisions. In a respectful conversation, they gained the clarity which was required. This meeting resulted in letters to Council members from Gene, Chata and Mitch Katz, explaining the situation. This served to halt any additional rumors. She went on to say that overall she felt good about what happened. It was respectful and productive. She wanted to underscore this difference, which she described as having righted the wrongs from before. Kathleen said that the message, "Do It Again, Do It Right," could be seen as a gift that Gene has left the HPPC.

Active Participation of HPPC Members

She went on to mention that the participants in the meeting had all asked important and detailed questions regarding the concept vote and the Bylaws changes. In the past, agendas were packed and often substantive discussion did not happen. People were prone to abstaining and refraining from talking. She observed real growth within this Council, and stated that what happened today came out of the pain, difficulty and lessons learned from last year. This year, the Council has had incredible contributions from new members. Everyone acting on the various ad hoc committees

and task forces has shown a true commitment. She mentioned that it was very appropriate that John Newmeyer had asserted the rights of the Council to new epidemiological information, which is so relevant to the work of this planning body. She called the Council a powerful group. She also stated that, as things loom in the horizon, the Council's strengths will be tested. She stated that the Council members should defend their right to the support they need, and she encouraged them to think about the kind of help they will need.

Process Evaluation Interviews
As for the Process Evaluation, Kathleen mentioned that the evaluators are still in the midst of interviews. They will report back with a composite picture of the strengths, challenges and experiences of the Council and committee members, once they have completed the last interviews.

8. COMMITTEE UPDATES

Linkages Committee, presented by Sacul and Chata:

- Committee has met once.
- Addressed cultural competence, inclusive of discussion about the definition of culture.
- Discussed the desire to help the DPH address cultural competence of its contractors.
- Discussed possible development of a tool that will be used to determine cultural competence of providers.
- This is only the beginning of much work and dialogue for this committee.

Sacul then added that she felt good about working with the members of the Council. She said (in agreement with Kathleen Roe's previous statements), that there is a trend of energy that motivates her. She then addressed Gene, saying that she believes the Council is losing something special.

Membership Committee, presented by Jelousy:

- Committee has met twice.
- They have developed a flyer to recruit some new members.
- The flyer was recently included in the Castro-Lions Newsletter.
- Addressed Bylaw revisions (which were approved at this meeting).
- Currently developing recruitment & retention strategies.
- Looking at the possibility of creating PSAs.
- Creating a Public Relations Plan, to go into the community.
- Planning orientation for new members, as well as a retreat.

Jelousy also requested of the Council any input that members might have in regards to recruitment and retention.

Chata added that the issue of recruitment for committees was discussed in the last Steering Committee meeting. He mentioned that the Steering Committee will be looking at this more, and will be drawing committee members from the Council membership as well.

Steven asked the Council members present how they felt about baseball. He went on to explain that the Membership Committee is currently considering organizing a 'Giants game day' for the Council, as a possible membership recruitment and retention notion. This was well-received by the Council members present.

Assessment Committee, presented by Maria:

- Committee has met twice.
- Good group of people, everyone has something to contribute.
- They currently have a total of 9 members. However, there are 2 more community members in the process of joining, which will then bring the total to 11 voting members.
- First meeting included presentations by Kerrington Osborne and Cynthia Gomez, as well as clarification on the Matrix, and the 4 Phases of the Priority-Setting Model.
- Second meeting included presentations on the resource allocation process. There were different perspectives offered by Lyn, Valerie, Jimmie, and Ana Claire.
- Currently moving toward discussing where they are going and how they are going to get there.

Maria mentioned that, at their first meeting, the Assessment Committee recommended that Kerrington and Cynthia present to the Council. Chata responded that this had been discussed and agreed upon. They were scheduled to present at the upcoming May 15th meeting.

Strategic Evaluation Committee, presented by Liz and Bethsaida:

- Discussed how Strategic Evaluation will go this year.
- Talked about an assessment of current agencies' ability to do required evaluation.
- Talked about what to do when information from assessment comes in.
- Talked about doing an inventory of research done on effectiveness of prevention interventions, to determine evaluation research gaps for Council.
- Elected Committee Chair Roberto Garcia.

9. CLOSURE/EVALUATION

Chata made final announcements about upcoming meetings and the Shanti reunion. He reminded everyone to fill out the evaluation forms. He then mentioned that he had originally planned to bring a card for Gene, but had not been able to do so. He requested that, if anyone had something they wanted to say to Gene, they use the dialogue boxes.

Enclosed with These Minutes (for those absent):

- Attachment 1: Year 4 Process Evaluation "Participant Dialogue" for 4/17/97, and "Community Outreach Form".

- Attachment 2: Community Planning Leadership and Orientation Trainings Brochure

- Attachment 3: Options for Supplemental Funding, CDC Cooperative Agreement 1997 Draft

Minutes Recorded by: Amalia Fernandez-Niewendorp and Mary Irvine, Polaris R & D
Minutes Approved by: Interim DPH Co-Chair Tracey Packer and Community Co-Chair Chata

Note: AIDS OFFICE LOCATION

HIV PREVENTION PLANNING COUNCIL MEETING

May 15, 1997
3:00 PM to 6:00 PM
AIDS Office
25 Van Ness Avenue (Room 330A)
San Francisco

Meeting called by: **Co-Chairs:**
Tracey Packer (interim)
Ellen Goldstein
Ronnie Ashley (Chata)

Please read: **Agenda**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Food/Welcome/Introductions/Announcements	Chata	3:00 - 3:10 PM
2. Guest Presentation: **Historical Overview of the HPPC Priority Setting Process**	Cynthia Gomez and Kerrington Osborne	3:10 - 3:50 PM
3. Technical Support to the Council	Chata/Ellen	3:50 - 4:05 PM
4. Break		4:05 - 4:15 PM
5. Committee Meetings		4:15 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC & Committee Meetings :

Thursday, May 22, 1997, 3-6 PM, First Unitarian Church - Franklin & Geary Streets

Thursday, June 12, 1997, 3-6 PM, First Unitarian Church - Franklin & Geary Streets

Thursday, June 19*, 1997, 3-6 PM, AIDS Office - 25 Van Ness Ave. 3rd Floor

* *(HPPC will meet from 3:00 to 4:00 PM and Committees will meet from 4:00 to 6:00 PM)*

NOTE: Room Assignments for May 15th committee meetings:

Assessment Committee - Training Room A (5th Floor)

Membership Committee -Conference Room (5th Floor)

Linkages Committee - Room 330A (3rd Floor)

Strategic Evaluation Committee -Room 330B (3rd Floor)

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HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for May 15, 1997

*** Please note in your calendar any meeting times that apply to you: ***

Council Meetings:	♦ Thurs., June 12, 3-6 p.m., @ 1187 Franklin Street ♦ Thurs., June 26, 3-6 p.m., @ 1187 Franklin Street
HPPC + Committee Meetings:	♦ Thurs., June 19, 3-6 p.m., @ 25 Van Ness Avenue

Members Present:
Ronnie (Chata) Ashley
Roberto Garcia
Ellen Goldstein
Liz Highleyman
Jelousy Jiggetts
Sacul L'Adnbre
Askia Muhammad
Jimmie Naritomi
John Newmeyer
Henry Ocampo
Tracey Packer
Dawn Passar
Joel Reyna
María Rinaldi
Bethsaida Ruiz
Steven Sams

Members Absent:
Barbara Adler
Isabel Auerbach
Kevin Gogin
Vic Hernandez
J. Colin Partridge
Sandy Simms

Leave of Absence:
Jennifer Lorvick

Guests:
Michael Discepola, AHP
Cynthia Gomez, CAPS
Cynthia Laird, B.A.R.
K. Osborne, Sup. Yaki's Office
Robin Serrahn, St. Anthony's
Stacy Vogan, HIV PTC

AIDS Office Staff:
Delia Garcia
Valerie Kegebein
Mike Pendo

Harder + Co./Polaris, Inc.:
Ellen Irie, Harder + Co.
Martin Forst, Polaris
Mary Irvine, Polaris
Steven LaFrance, Harder + Co.
Lyn Paleo, Harder + Co.

HPPC Process Evaluation Team:
Pali Basi
Ruel Caneda
Raquelle Caras
Cathleen Farrell
Cely Queiroz
Kathleen Roe
Kevin Roe

1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Chata convened the meeting shortly after 3:00 p.m. and asked that people introduce themselves.

Announcements:

Steven Sams-- HIV Advocacy Network

- Steven informed the Council of the HIV Advocacy Network (HAN), which occasionally puts out Action Alerts. He distributed copies of a fax detailing the particulars (see Attachment 1). To summarize, he explained that Congress and the President were about to balance the budget, at the expense of Medicaid. He explained that the fax lists names of California's Congressional Delegation, as well as their fax numbers. He asked those present to fax a commentary to the Delegates urging that they not balance the budget on the backs of those who can't afford it.

Chata – New DPH Co-Chair

- Chata introduced and welcomed Tracey Packer to the Council.

  Tracey informed the Council that she has been working with the AIDS Office for almost 5 years, and has been working on the planning process almost from the beginning. She also expressed how much she has enjoyed working with the AIDS Office team. She said that she has experienced the tough times and the good times of the HPPC, and that what

is happening this year is a reinforcement of the good times and the strong partnership that has been created. She said that the Council will be able to put a mechanism into place that will help it confront difficulties. She expressed her excitement at the implementation of the HPPC Plan. She also stated that she will be representing the DPH and working closely with the AIDS Office staff to ensure that she is able to provide the Council and the DPH with correct and appropriate information. Acting as a liaison for the HPPC and the DPH, she will attempt to make the communication process effective. In closing, she thanked everyone for this opportunity to be involved.

Chata - Additional Council Meeting

- Chata made a brief announcement regarding an additional Council meeting scheduled for May 22, 1997 at the Unitarian Church, from 3 to 6 p.m. He mentioned that this meeting had been scheduled to discuss and vote on the Supplemental Funding options. He informed the Council that the Supplemental Funding Task Force (SFTF) had met earlier that morning, but would not be presenting its final product to the full Council for a vote until the meeting on the 22nd. He mentioned that there might also be other issues on the agenda for that meeting date.

Chata -- Notification of Member Absence

- Chata mentioned that Barbara Adler had called earlier to inform him that she would not be able to attend today's meeting.

2. GUEST PRESENTATION:

Ellen introduced the guest presentation. She said that Kerrington Osborne and Cynthia Gomez had been invited by the Assessment Committee, to provide the Council with a historical overview of the HPPC priority setting process. Both presenters had served as co-chairs of the HPPC during the first two years of the Council, and they were both involved in the priority setting process.

Kerrington Osborne (former HPPC co-chair), Office of Supervisor Michael Yaki

General History of the Community Planning Process and the SF Plan

Kerrington discussed what was accomplished through the HPPC process, which resulted in a paradigm (model) shift that has many people throughout the nation thinking differently about HIV prevention. He went on to explain that, at one time, the DPH had sole responsibility for local prevention services planning -- inclusive of resource allocation, prioritization, and strategies and interventions -- particularly in regards to what was funded in the RFP process. *(Editorial note from Valerie K.: The DPH began soliciting community input in 1990.)* Kerrington explained that the weight of planning responsibility shifted when the CDC came up with the innovative idea (with much community input around the country and backing especially from Congresswoman Nancy Pelosi) to bring HIV-infected people, community people, at-risk populations, service providers, and professionals to the table to work on prevention planning. He went on to say that, with the CDC guidance, the HPPC created the framework used in setting up the chapters of the Plan. He said that San Francisco was fortunate to have had so much data regarding HIV. He went on to explain that the Plan was a tool to look at how San Francisco could improve the implementation of community process in response to the local epidemic. Kerrington explained that eventually the Council developed the process by which the formulas in the current Matrix were determined.

Elements of the Matrix
He then referred to the Plan for what he said were the most important components of the Matrix:

- *Relative Risk* refers to the efficiency of a particular act (assuming it is unprotected) for transmitting HIV. He mentioned that all scientific evidence suggests that blood-to-blood contact is the most effective route of HIV transmission; hence it was determined that sharing needles is the most efficient mode of transmission. He explained that they used vaginal receptive sex as the reference point for the relative risk, because the most information was available on this mode of transmission. He went to on to give the Council an example.

  If relative risk of (unprotected) vaginal receptive sex is set at 3,
  then relative risk of (unsterile) needle-sharing should be 12.
  (Needle-sharing is 4 times more effective at transmitting the virus than vaginal sex.)

- *BRPs* refer to the specific behavioral risk populations. The formula for the Matrix calculates basic risk (by BRP) of contracting HIV, according to the **relative risk** of a behavior and the **average frequency** of its practice in a BRP.

Notable Variation in Relative Risk within a BRP
Kerrington mentioned that relative risk had been found to be higher for post-operative MTF transgendered persons practicing vaginal receptive sex (within the general BRPs including FSM: FSM, FSM&F, FSM-IDU, and FSM&F-IDU). He stated that the Council had learned that a surgically constructed vagina was similar to an anus in its susceptibility to tearing during sex (particularly during the healing process after surgery).

Council's Choice of Terms and Factors
Kerrington mentioned that the decision to use the terms "males" and "females" (instead of "men" and "women") helped to account for youth. Post-op. and pre-op. were added to address issues that arise with regard to the Transgendered population. Kerrington continued by saying that, through the BRPs, the Council was trying to account for everyone at risk for HIV in SF. He mentioned that people had noted the lack of ethnic/racial categories and had thought it meant that there were missing factors. The Council felt strongly that race and/or gender were not direct causes of HIV risk, while behaviors (influenced by other factors) can function as direct causes of transmission.

Cynthia Gomez, UCSF Center for AIDS Prevention Studies (CAPS)
History of Council's Prioritization by BRPs
Cynthia talked about why the decision was made to prioritize on the basis of behavioral risk populations, as opposed to some of the more commonly-identified populations that other states chose to use. She discussed the history of how the Council had made what was viewed nationally as a huge shift in how people had been thinking about populations and targeting. Usually, they had begun with the more traditional groups (e.g., gay men, IDUs). The Priority Setting Committee created a formula to explain how San Francisco would prioritize prevention services. She went on to report that they had run some different formulas -- factoring in population size, prevalence, and cost effectiveness -- and that the results of those formulas still placed MSMs and IDUs at the highest risk.

The full Council at that time felt that priorities and services needed to include other groups and other data, so they proposed a shift. Because the city of San Francisco had the largest viral availability of any metropolitan area in the United States, the Council felt that every group in San Francisco was facing HIV risk. Cynthia cautioned, however, that the actual risk depended on what particular behaviors people were engaging in. The Priority Setting Committee decided to look at the mode of transmission (blood vs. semen vs. other fluids) and behaviors.

The formula as HPPC knows it now was created for the Matrix, which includes the following:

- Relative risk;
- Behavioral frequency;
- Prevalence (who is affected); and
- Population size (to take into account that prevention could be equal, but population proportions differ).

Cynthia explained that the Council also wanted to incorporate co-factors, cultural issues, biological issues, etc. into the prioritization process. She said that, although the intent was good and the outcome could probably have been good, the group had not been able to come to a consensus on how to incorporate these co-factors into the Matrix. She stated that the Council felt strongly that prevention funding should be reaching people who could potentially be exposed to HIV, according to the behavioral model.

Goal and Guiding Principles Driving the 1994-1995 HPPC Approach to Prioritization
Kerrington added that he also wanted to inform this new Council of the goal and the guiding principles according to which the 1994-1995 Council was operating.

Goal:

- To reduce new infections as close to zero as possible.

Guiding Principles:

- Respect sexual practices; be sex-positive.
- Certain things reduce HIV risk (e.g., sterile needles, latex barriers).

Discussion, Questions and Answers:
Ellen opened the floor for questions from members.

John mentioned that, when he originally approached the HPPC model last year as an outsider and an epidemiologist, he had felt skeptical about it. However, he claimed that, after reading all of it, he now is a defender of the model. He added that, if there is a problem with this model, it lies in the actual numbers. He recommended that this problem could be solved through use of information from the epidemiological Consensus Meeting held on 5/12/97.

Cynthia thanked John, and went on to say that the numbers in the formula did include consensus estimates from researchers around the country (tracked down by Lyn Paleo). Cynthia stated that the Council saw the numbers in the Matrix as averages, and that individual agencies would be able to give more specific data on their populations, to raise the scores using their proof of higher behavioral frequency or higher prevalence. Cynthia also mentioned that a lot of technical

assistance occurred prior to the RFP, to help agencies provide this kind of data on their populations; but the technical assistance providers found that most agencies did not know how to show that their clients were at any specific HIV risk. She also stated that, with the Matrix formula, the HPPC had expected providers to be able to show the behaviors of their clients.

Chata asked for the presenters' opinions regarding why the model did not work and any suggestions they might have for reviewing the overall model. Cynthia responded that the model was not implemented as it was designed, due to a cutoff point for identifying the highest-risk behavioral groups. She said that she felt the model itself was good. Valerie clarified that, at the end of Cynthia's and Kerrington's planning year, the Council had not imposed a grouped ranking of BRPs in the Matrix. The new Council chose to establish a cut-off point for priority funding for the highest-risk BRPs. The HPPC gave the responsibility for setting the actual cut-off score to the AIDS Office, and the AIDS Office made the decision based on recommendations from the HPPC.

Kerrington interjected with an example of how to use the formula (multiplying frequency by the relative risk):

> An MSM-IDU uses unsterile needles for injection 70 times a year, on average. The bottom number in the Matrix is the product of that estimated average annual frequency (70) times (x) the relative risk (12) at the top, which then results in 840 total score (70 x 12=840). This bottom number is then added to the bottom numbers in the other columns for that row, to produce the Total Phase I score (or basic risk score) for that behavioral risk population. He mentioned that the inclusion of population size was intended to take into account the potential for high rates of infection in a smaller population, which could annihilate the population (the danger faced by the Native American communities).

John mentioned that it might have been better to roughly estimate the population size and then round off, instead of taking an absolute number and turning it into a logarithm. Kerrington responded that the Council had had that discussion but had reached a different consensus.

Steven Sams asked about the Hispanic origins chart in the Plan. He was curious as to how it actually affects the estimates and scores for population size, since many Asians & Native Americans have Hispanic origins as part of their ethnic makeup. Kerrington explained that they had used a plethora of data (demographic studies done in SF) -- self-identification, door-to-door census tracts, and information on homeless communities. Ellen added that ethnicity had not played into the numbers of the Matrix, because it was strictly behavioral, not ethnic or racial. Population size for the Matrix was based on estimates of the size of **behavioral** groups.

Steven Sams asked further how the Council split the BRPs by ethnicity to determine funding. He was interested in understanding who exactly was getting served under certain ethnic breakdowns. Kerrington said this was not his understanding of how things got funded. He went on to say that the Council had seen data that showed more instances of anal receptive, unprotected intercourse among African American MSMs than other MSM populations. What would appear on paper as an agency getting funded to serve African American MSMs does not mean that the Matrix did not work or that providers didn't have to show elevated risk.

Ellen moved to wind up the presentation. She thanked Cynthia and Kerrington for their sharing of information. She explained that the purpose of the presentation was to hear the struggles of a planning group similar to the current HPPC, over how to best prioritize (given the limitations of available data). She also explained that the presentation was intended to educate the Council on the BRP model.

Kerrington added that the earlier Council and Priority Setting Committee never said that one's ethnic or gender identity was irrelevant. He said they saw the challenge as linking that identity to a risk behavior. He went on to state that he feels strongly that identity (gender/ethnicity/age) is an important part of the existing Plan. He spoke of the challenge the Council must now face, to go back to the co-factors and cultural differences and link them to the behaviors. Cynthia explained that they had wanted to avoid saying that one ethnic/racial group was more important than another. She said that the Council members had had to let go of their personal agendas and sit at the table as planners for the city of SF. She stated that they had not tried to make a "colorless" formula, but rather a non-racist formula. They had wanted to look at who was at risk because of what they do, and then add in the other factors (i.e., covariates and co-factors).

3. TECHNICAL SUPPORT TO COUNCIL

Chata distributed a draft letter to the DPH regarding rumored cuts to the HPPC support contracts (see Attachment 2). He commented that this Council can't make sound decisions based on rumors, innuendoes, and hearsay; it needs the facts. He requested that the Council members take time to read the draft letter from the community co-chairs to the DPH. Roberto said that he was unaware of what this discussion was about and requested some clarification. Chata informed the members that there had been meetings at the AIDS Office about the technical support contracts to the Council, inclusive of the process evaluation team, logistical support team, and technical support team. He stated that, although the co-chairs were aware of the discussions of cuts to these contracts, they had not heard why the cuts were deemed necessary. He stressed that any decisions about the support of this Council coming from outside the process and the Council's purview are unacceptable. He also said that any cuts crippling the Council's ability to do its work are unacceptable.

Maria said that, since she has been at this HPPC table, she has repeatedly heard the word "partnership" used. She asserted that she is tired of being involved in a "partnership" where the AIDS Office/DPH has more than 50% of the action/purview. She asked that it be made clear whether this is indeed a 50/50 partnership. If it is not, she requested that someone inform the Council of that fact. She added that it's extremely disappointing that decisions affecting the Council are being made without even consulting or informing the Council. She suggested that the difference in understanding over the roles of the Council and DPH might be the result of a cultural difference.

Chata went on to say that, with all due respect to the AIDS Office staff supporting this Council, this contract funding decision is happening outside of their control, and coming down from the higher leadership at the AIDS Office. Roberto requested that any facts established from this discussion and letter result in a response to the full HPPC.

Jimmie mentioned that it was difficult to discuss the issue without the benefit of all of the correct information. John agreed, and stated that the Council should be in a concerned and information-gathering mode at this point, since it seems as if there is nothing more than hearsay available at this stage. Chata mentioned that the information about intended cuts was indeed more than

hearsay and rumors. He said that it was factual that a demand had come down from AIDS Office leadership, which had led to a re-examination of the contract with a discussion about cuts. He went on to say that the co-chairs did not yet know all of the particulars about what is being cut -- support services, monetary amounts, etc.

Liz asked for clarification on page 2, question 5 of the draft letter, and was assured by Chata that the HPPC technical support staff have been working this year without a contract or pay. Ellen then reviewed the 5 questions that were being asked in the letter. She asked for a straw poll of those present, to see if there was support for the co-chairs sending the letter on behalf of the Council. Everyone present raised their hands in support.

Jimmie recommended that the co-chairs "respectfully request," answers from the AIDS Office, and not state that they "require" answers. Chata told the Council that the co-chairs are respectfully demanding an explanation, and want to let the DPH know that it is in the purview of the HPPC to address cuts to the planning support contract. He added that the HPPC will hold the DPH accountable through a letter of concurrence. Ellen reiterated that the underlying question is whether all of this work really happens in context of a partnership. She also wanted to acknowledge all of Chata's work in bringing this information to light.

4. EVALUATION

Kevin distributed to the members present Participant Dialogue forms, with boxes for input on this Council meeting and/or anything from the committee meetings.

5. BREAK

6. COMMITTEE MEETINGS

Enclosed with These Minutes (for those absent):

- Attachment 1: HIV Advocacy Network *Action Alert.*
- Attachment 2: Draft Letter to Dr. Hernandez and Dr. Katz.
- Attachment 3: Year 4 Process Evaluation Results and Participant Dialogue for 5/8/97.
- Attachment 4: Approved Bylaws.

Enclosed with These Minutes (for all members):

- Attachment 5: Membership Committee notice regarding new members.

Minutes Recorded by: Mary Irvine
Minutes Transcribed (from tape and handwritten notes) by: Amalia Fernandez-Niewendorp
Minutes Approved by: A.O. Co-chair Tracey Packer (w/ input from V.K.), and Community Co-chair Ellen Goldstein.

HIV PREVENTION PLANNING COUNCIL MEETING

May 22, 1997
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer

Please read: **Agenda and minutes of May 8, 1997**
***Please bring*:** **Minutes and Agenda**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Food/Welcome/Introductions/Announcements	Ellen Goldstein	3:00 - 3:15 PM
2. Public Comment	Tracey Packer	3:15 - 3:35 PM
3. Minutes from May 8th	Tracey Packer	3:35 - 3:40 PM
4. Delta Project Update	Valerie Kegebein	3:40 - 3:50 PM
5. Supplemental Options Discussion & Vote	Ellen Goldstein	3:50 - 4:40 PM
6. Break		4:40 - 4:50 PM
7. Supplemental Options Discussion (continued)	Ellen Goldstein	4:50 - 5:50 PM
8. Closure/Evaluation	Kathleen Roe	5:50 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC Meeting - Thursday, June 12, 1997, 3-6 PM, First Unitarian Church 1187 Franklin Street (@ Geary)

HPPC & Committee Meetings - Thursday, June 19, 1997, 3-6 PM, AIDS Office (3rd Floor) 25 Van Ness Ave.

(HPPC will meet from 3:00 to 4:00 PM and Committees will meet from 4:00 to 6:00 PM)

DPH

HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for May 22, 1997

*** Please note in your calendar any meeting times that apply to you: ***

HPPC Meetings:	♦ Thurs., June 12th, 3-6 p.m. @ 1187 Franklin St.
HPPC & Committee Meetings:	♦ Thurs., June 19th, 3-6 p.m. @ AIDS Office

Members Present:	**Members Absent:**	**AIDS Office Staff:**
Barbara Adler	Isabel Auerbach	Brian Dobrow
Ronnie (Chata) Ashley	Roberto Garcia	Valerie Kegebein
Ellen Goldstein	Kevin Gogin	Mike Pendo
Liz Highleyman	Vic Hernandez	
Jelousy Jiggetts	Sandy Simms	**Guests:**
Sacul L'Adnbre		Cynthia Laird, B.A.R.
Askia Muhammad	**Leave of Absence**	Loras Ojeda, Mobilization
Jimmie Naritomi	Jennifer Lorvick	Hank Wilson, ACT UP G.G.
John Newmeyer		
Henry Ocampo	**Harder + Co./Polaris, Inc.:**	
Tracey Packer	Amalia Fernandez-Niewendorp, Polaris	
Colin Partridge	Martin Forst, Polaris	
Dawn Passar	Ellen Irie, Harder + Co.	
Joel Reyna		
María Rinaldi	**HPPC Process Evaluation Team:**	
Bethsaida Ruiz	Kathleen Roe	
Steven Sams	Kevin Roe	

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1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Ellen convened the meeting shortly after 3:00 p.m., and everyone stated their name.

Announcements:

Steven Sams -- Membership Committee Activity "Giants Game Day"

- Steven Sams informed the Council that the Membership Committee had made arrangements with Pacific Bell for an HPPC Giants Game Day. Ellen asked for a straw vote to decide which of the two game day/time options members wanted. The group voted to go to the Giants vs. Dodgers game on June 20th. The Monkees Concert begins at 6:00 p.m. and the game time is 7:05 p.m. 100 tickets will be available at the AIDS Office on a first-come, first-serve basis for Council members and their family/friends. Please call Tracey Packer at 415-554-9992 to reserve tickets.

Steven Sams-- AIDS Walk San Francisco 1997

- Steven Sams distributed a two page invitation to join the Pacific Bell walk team. Anyone interested in participating will receive breakfast, lunch, a T-shirt, and other surprises. The walk is scheduled for July 20, 1997 at Golden Gate Park.

Dawn -- Harvey Milk Gay, Lesbian and Bisexual Democratic Club Annual Dinner

- Dawn informed Council members of the Harvey Milk Gay, Lesbian and Bisexual Democratic Club Annual Dinner and awards, which will be honoring Cecil Williams this year. The event is scheduled for May 22, 1997 at 7:00 p.m. Tickets for the dinner are $50.00 each.

Kathleen -- Evaluation Comments

- Kathleen apologized and pointed out that the process evaluation participant dialogue boxes for the 5/15/97 meeting are missing input from some of the Council members. The input will be incorporated into the next participant dialogue handout.

Tracey -- New Members

- Tracey explained that, in the past months, all new Council members have been notified of their appointments, but not all have affirmed their participation. The following is a list of these new members:

1) Marianna Balquiedra*	7) Sonja Mackenzie
2) Elizabeth Davis	8) Lisa Moore
3) Deja Dior-Britt	9) James Rapues
4) Michael Discepola	10) John Blake West
5) Brenda Escobar	11) Thomas Zickgraf
6) Monica Lee*	12) Marcos Banalos

(* UPDATE: Marianna Balquiedra and Monica Lee have declined their appointments.)

New members will participate in an orientation meeting on June 10th and will begin attending Council meetings on June 12, 1997. They will be involved in the Council discussions, but they will not participate in votes until August 1, 1997.

Maria asked about any recent resignations and was informed that there had been only been one resignation, from Hector Carrillo. Although he will no longer be a member of the Council, he will be participating in the Linkages Committee as a community member.

Tracey also explained that Jennifer Lorvick had requested and been granted by the co-chairs a leave of absence until September 1997.

In view of the recent resignations, Jimmie asked for an update from the co-chairs as to how many voting Council members there are. Tracey responded that currently there were 22 members. Once new member come on board, there will be approximately 34 Council members.

Tracey -- Price Fellowships for HIV Prevention Leadership

- Tracey explained that the CDC awards the Price Fellowships for HIV Prevention Leadership to representatives of non-governmental organizations (NGOs). These fellowships bring selected NGO representatives to the CDC in Atlanta, Georgia for a period of 4 weeks. During this time, they are able to learn about the CDC, as well as provide their perspectives to the CDC. The goals of the fellowship are:

(1) Provide CDC with expertise and different perspectives about the prevention activities, organizational structure and capacity, and experiences of non-governmental organizations;

(2) Provide three NGO leaders an opportunity to visit the CDC in Atlanta, Georgia, and, through interaction with CDC scientist and health professionals,

a) complete a project or pursue a special interest, and
b) learn more about HIV prevention at the national level; and

(3) Facilitate exchange about important HIV/AIDS prevention issues between three NGO leaders and CDC personnel, state and local health department representatives, and other NGO leaders in the United States.

Anyone interested can request the application and fellowship information from Tracey. The deadline for the applications is June 13, 1997, 5:00 p.m. Eastern time. The fellowship program will be implemented September 2, 1997 through September 30, 1997.

Chata - Meeting Changes

- Chata explained that, due to input from Council members regarding the 3rd Thursday of every month, the co-chairs have established some changes to the meeting schedule. Up to this point, the 3rd Thursday of every month has been used for both Open Forum/Open-Mike (1 hour) and committee work (2 hours). Due to the committees' request for more time for their work, the following changes will go into effect as of July 1997:

2nd Thursday of the month:	Official Council Meeting	3:00 - 6:00 p.m.
* 4th Thursday of the month:	Open Forum/Open-Mike Meeting.	3:00 - 5:00 p.m.

(* NOTE: includes the option that, if a second full Council meeting is required in any given month, the Open Forum/Open-Mike Council meeting will be postponed for the next month.)

Chata - Letter of Response Regarding Planning Support Contracts

- Chata referred to the letter of response from Mitch Katz and Sandra Hernandez regarding the Planning Support Contract. The response was not satisfactory to the community co-chairs; they feel that several issues and questions were not addressed. At this time, the HPPC community co-chairs were composing a second letter, that would be sent to Mitch Katz and Sandra Hernandez, as well as to Council members.

2. PUBLIC COMMENT

Tracey introduced Hank Wilson and Maria Rinaldi for Public Comment.

Hank Wilson, ACT UP Golden Gate

- ***20th Anniversary of the Harvey Milk Gay, Lesbian and Bisexual Democratic Club***: As a founding member the Harvey Milk Gay, Lesbian and Bisexual Democratic Club, he expressed his satisfaction at being able to celebrate the 20th Anniversary of the Club.

- ***Candle Light March***: Hank stated that this year's march reflected a disempowerment of PWAs. He expressed his disappointment at the lack of representation of PWAs. He explained that -- unlike the initial marches, where PWAs spoke for themselves and their needs, fears and experiences -- the featured speakers of this year's march consisted of: Mayor Willie Brown, Assemblywoman Carol Migden, Supervisor Susan Leal, Supervisor Sue Bierman, Congresswoman Nancy Pelosi, and the HIV-negative Executive Director of an AIDS organization as the keynote speaker. He stated that the march should have been an opportunity to discuss and educate people that not everyone was responding well to the new drugs. He mentioned the importance of having someone infected present first-hand their experience with the new drugs (what is and is not working). He expressed that involvement of PWAs is as beneficial to prevention as it is to care and treatment, and is the only way to get an accurate picture of the situation. He stated that, for prevention messages, politicians cannot inspire as

well as PWAs. He challenged the Council to ask and provide input about the lack of PWAs at this year's march.

- ***Post-Exposure Prophylaxis (PEP):*** He stated his concerns about the new treatment protocol and how it will be incorporated into prevention (e.g., HIV testing, counseling, etc.). He posed the question to the Council as to what will happen when PEP becomes available and begins to be advertised throughout the community. He asked that the Council consider the ramifications of PEP and what is actually known about this treatment (e.g., is it easy to take or administer, and what are the side effects?). He went on to ask whether the Center for AIDS Prevention Studies (CAPS) had any information to share about PEP. He explained that, as PEP gains momentum, there will be with mixed reactions from the communities and providers. Problems will arise even if the implementation of PEP is done properly, but much more severe problems will arise if it is done incorrectly. Hank suggested that the Council review the HIV Prevention Plan to see how it may address the issues surrounding PEP, and (if it does not) make every attempt to include it in the Plan in the future.

Maria Rinaldi, Instituto Familiar De La Raza, Inc.

- ***Undocumented Immigrants Amnesty Petition:*** Maria asked that the Council take into consideration the endorsement of a petition for amnesty of undocumented immigrants. She explained that, although it may seem as if the initiative is strictly about undocumented immigrants, the issue has significance to the ability of providers to access the population and relate the prevention message. She pointed out that the petition is a nationwide effort, and not restricted to San Francisco. She explained that she did not have the petition at this time, but could provide it at the next Council meeting, if the Council was in agreement about endorsing it.

Questions for Presenters

- Tracey asked for any questions or comments for the presenters. Barbara expressed her appreciation at being exposed to the information provided by the presenters. She stated that it was fitting information for the co-factors discussions that members are having in committees, as well as in the Council. She explained that all of the issues mentioned by the presenters relate to co-factors, and it is helpful to hear about them as members attempt to address them.

- Ellen responded to Hank's statement regarding the information available from CAPS. She stated that CAPS has created a second review fact sheet that addresses the implications of new treatments and PEP for prevention. It will be published in the next weeks and will go out to 5,000 people nationally, including policy makers, politicians and providers. She stated that the questions are being asked, but answers have yet to become clear.

- Maria commented that, as an HIV-negative woman, she could only speculate on the real issues faced by people who are HIV-positive. She said that one of the most powerful prevention tools that she uses is the speakers bureau. She stated that there is nothing more powerful than first-hand experience, and that it is unacceptable to hear that the leadership of this community is being taken away from PWAs.

- Questions to Maria included the time frame for the petition and the possibility of seeing a list of other agencies endorsing the petition. Maria responded that she would provide the petition and the endorsing agencies list at the next meeting. Tracey stated that this issue would be placed on the June 12th agenda. Tracey thanked both presenters.

3. APPROVAL OF MINUTES FROM MAY 8, 1997

Tracey asked if there were any comments, questions, or corrections for the May 8th minutes.

Jimmie stated that on Page 6, paragraph 3, the comment should read: "...their partners' **injection drug use** behaviors," and not "...their partners' behaviors." The second correction he had was for Page 9, paragraph 2, where the statement should read: "...API under CDC Direct funding **relevant to Behavioral Risk group # 1,**" and not "...API under CDC Direct funding."

Chata mentioned that Barbara Adler had been an excused absence, which he failed to mention at the last meeting.

Dawn pointed out that on Page 6, paragraph 4, it should read: "...Women's Program **with** the Exotic Dancer's Alliance," and not "...Women's Program under the Exotic Dancer's Alliance."

With the above-mentioned changes, the minutes of 5/08/97 were approved by a quorum with one abstention.

4. CDC SUPPLEMENTAL OPTIONS DISCUSSION AND VOTE

Chata invited Valerie to join Ellen in presenting the revised CDC Supplemental funding options. The Supplemental Funding Task Force (SFTF) had convened earlier this morning and had spent most of the day combining and narrowing the previous seven options to a list of three options. Ellen reiterated that the Council had been notified of available CDC Supplemental Funding in the amount of $719,105.00. This funding is designated to fill some of the gaps left after the initial funding awards. At the last meeting, the Council passed a concept vote that determined that the SFTF was going in the right direction, narrowing down all of the possible ways to spend the funding. The following are the three options:

- **Option 1)** Fund unmet needs among bisexual men, women, young commercial sex workers, IDUs, and people of color.
- **Option 2)** Fund prevention education/training component of PEP, education on Protease Inhibitors, primary and secondary prevention, and linkage between HIV/STD education.
- **Option 3)** Fund programs for CTRPN for lab cost only.

The SFTF sought specifically to narrow down the options and to decide which current populations were to be addressed in Option 1. Ellen explained the process by which they arrived at the population categories slate they are presenting to the Council. The slate was determined by looking at BRPs, co-factors and other defining characteristics/covariates (including age, ethnicity, gender identity, and sexual orientation). Each member of the SFTF then came up with four highest-priority populations they wanted to address with the Supplemental funding. They then spent a fair amount of time developing criteria for evaluating the 30 or so population options. The five evaluation criteria the SFTF developed were:

1. Gaps in funding (look at existing funding through 015 and 016).
2. Comparing prevalence to funding (high prevalence, low funding).
3. BRPs (size and prevalence).
4. Incidence (where the epidemic is going).
5. Co-factors (missed in previous funding decisions).

They wanted to recognize all of the populations, but they understood that they would not be able to fund them all. At this point, each SFTF team member came up with two top-priority populations.

They took the list of sixteen and narrowed it down to nine populations of highest priority, by eliminating duplications and overlap. They looked at the Plan and current funding and determined the ranking of the nine population categories into: highest priority (1) and higher priority (2). The following slate depicts the ranking, populations and specifics.

Ranking	*Population*	*Specifics*
2	1. FSM	- risky partners, women of color
1	2. MSM MSM/F	- youth, emphasis on youth of color, all ethnicities (queer young men of color)
1	3. MSM - IDU MSM/F - IDU MSF - IDU	- including bisexually acting and African American
1	4. MSM MSM/F	- speed users (including leather, Tenderloin, dance clubs)
1	5. MSM MSM/F	- Native American - African American
2	6. MSM/F	- who don't identify as gay/bisexual (do not access services for gay/bisexual males).
2	7. FSM/F - IDU FSM - IDU	- women who inject - age appropriate interventions
2	8. MSM MSM/F.	- Native American, migrants (gay and non-gay-identified)
2	9. MSM/F	- Latino, immigrant, homeless, drug/alcohol use (including a focus on transgender)

Although there was not a full committee consensus for the population categories slate and all three options, there was a total agreement on the process.

Ellen, on behalf of the SFTF, presented these 3 options and nine population categories to the Council for discussion and approval.

Valerie explained that the DPH staff has developed potential implementation plans for this funding. It has not yet been approved, therefore it is subject to change. Currently, they are considering a combination approach to allocating these funds. San Francisco is receiving $719,105 in 1997, and probably another $719,105 in 1998. In addition to these funds, the AIDS Office recently heard that it will be receiving an additional $80,000-$94,000 dollars from the State of California. That particular funding has to be spent on a specific targeted project or intervention by the end of December of 1997. The concept would be to use some of that funding for one-time needs and specific gaps that could be covered quickly by putting the money into contracts, MOUs or something that could get out in 1997. Since there will be gaps in funding in 1998 due to overlapping funding streams in 1997, one of the ideas is to use some of the 1997 money to cover those gaps in the contracts for 1998.

The other part of the implementation would include RFPs for as much of the available money as possible in July of this year, with the intention to commence any new programs or additions to programs by January 1998. The RFP idea is to level the playing field and allow for an open and competitive process. To avoid any conflict of interest in the development and review of the RFP and that process, HPPC members without conflict of interest will be asked to review the RFP.

Valerie said that the SFTF recommendations have not been reviewed by the DPH AIDS Office management, therefore there is a potential for change as well as the possibility of other spending

priorities for the Supplemental funds. The Council must also recognize that funding more programs may create a need to fund an increase in staff at the AO to handle those contracts.

Once the Council has decided on the recommendations and implementation plan for funding, it will be forwarded to Dr. Katz for review. Any feedback, information or changes to the recommendations and implementation plan will be supplied to the Council as soon as possible through a separate mailing, an additional Council meeting or a regular Council meeting.

Chata inquired about whether the Council would be notified of any feedback, information or changes before the application deadline. It was explained that the application requires a letter of concurrence from the Council, and, since the application is due June 30, the letter will be on the agenda for the June 12, 1997 Council meeting. No changes will be made in the application after a letter of concurrence is approved by the Council.

Jimmie thanked and acknowledged all of the work the SFTF had put into the options and priorities. Since he did not have all of the charts and information that were used to make the decisions, it was difficult for him to arrive at a conclusion about the population categories slate. He stated two things about the current scenario that needed clarification:

1. The distinction between covariates and co-factors -- primarily the lack of specificity for some and not others.
2. The process of how and why interventions were identified, since there are specific gaps in prevention case management that were not being addressed on this slate.

Ellen responded that, in trying to be specific, they had discussed individual risk reduction and prevention case management for gay men of color, specifically Native and Latino gay men. The interventions were identified here because there was a desire to see more intensive interventions, as opposed to broader-reaching interventions, for those two populations. She added that selecting appropriate interventions, as well as determining the covariates and co-factors, will be a subsequent task.

John asked for a point of clarification between population categories #2 and #5. Ellen explained that, during the refining and revising process, the SFTF had looked at the gaps in services and had decided that #2 was just for gay youth (ages 15-24) of color and that #5 would be for both gay men and youth. She added that #5 specified Native and African Americans only, because the SFTF had information that API Wellness has received significant CDC funding through 704. They also looked at the funding levels for Latinos in BRP 3, and found them to be inadequate.

Jimmie asked for permission for a rebuttal regarding #5 and the CDC 704 funding. He wanted clarification as to what the CDC 704 funding was for. As he had mentioned before, the bulk of prevention case management funding used to go to his project, which is closing. He added that this has created a funding gap in the prevention case management for the API population, which has not been addressed on this slate.

Point of clarification from Henry and Dawn: the CDC 704 funding discussed earlier was specifically for theater programs and media campaigns.

Ellen asked that they discuss each option individually, to determine if the Council was in agreement or disagreement about the options. She began by asking the Council for input regarding the acceptance of the slate under Option 1, as proposed.

Jimmie stated that, at this point, he could not vote on the package as is. He would require more information and specifics. Liz raised the question of how many of the nine population categories (all or some?) would be funded, if the Council voted for the package as is. Ellen responded that the list of nine population categories and interventions was a list of priorities that they were presenting to the AIDS Office staff, who would determine how many populations could be funded, based on the cost of interventions.

Steven Sams explained that, before reaching the current slate of nine population categories, the SFTF looked at 80 to 100 populations. He assured the Council members that they had used a lot of specific information in determining these nine population categories, inclusive of incidence, current prevention funding, prevalence, population base, co-factors, etc. They were aware of the many questions that needed to be asked, and they attempted to addressed them in their process.

A motion and a second were made to accept Option 1, inclusive of the population category slate.

In favor:	11
Opposed:	1
Abstentions:	3

Motion carried.

Ellen requested any specific interventions or categories that members wanted to recommend for incorporation into the next level of development of the options and population categories. She also asked those who had opposed the motion or abstained to explain their concerns. Bethsaida stated that she needed more time to consider the options as they were, and would need to see more information about the types of interventions proposed. John expressed his concern over the lack of time available for review and dialogue about the Options and the slate of population categories. He would like to see more focus on older gay men, because of high levels of incidence reported at the Consensus meeting. He also wanted more focus on men who inject drugs.

Ellen explained that population category 3 was meant for men who have sex with anybody and inject drugs -- primarily African Americans, but not precluding men of other ethnicities. As for population category 4, it was intended for speed-using men who have sex with either men or women, and it does not preclude people who take speed by various means other than injection. Steven added that the use of the different venues in population category 4 -- leather, Tenderloin, dance clubs -- would address many different age groups.

John stated that recent information indicates that 50 % of new HIV infections are among MSM over 30 years old, and therefore the Council should target them as well. Ellen stated that the categories include men who have sex with males and/or females and are not limited to a specific age group. Older MSMs can be captured in population categories 3, 4, 5, 6, 8, and 9.

Jimmie expressed his concern that the existing population categories, with maybe two exceptions, reflect the BRPs 1-7 -- which are already being addressed through RFPs 015 & 016 and the current CDC funding that is pending (mentioned earlier by Valerie). He expressed that he was unable to commit to the slate with the available information. He would have liked to see more defined categories and interventions. He added that there was a gap in prevention case management that needed to be addressed.

Chata reiterated that they had looked at both the CDC funding and the AO funding by behavior groups, race/ethnicity and interventions. The intent of the SFTF had been to specify the options and population categories, which they did. However, he understood that more information could have been beneficial. Ellen added that the goal of the SFTF had been to present priorities with which the whole Council could feel comfortable. She requested that members present any information or specific concerns they had, so that the SFTF could incorporate them into the slate or respond to any questions of clarification.

Henry stated that he also needed more information about how the SFTF had taken 80-100 categories and narrowed them down to nine. He would like to know what some of the earlier discussions had been. He added that he needed a better understanding of how it had happened, and then he might be more comfortable with it. Askia responded that, as one of the SFTF members, he could understand how members of the Council were feeling, since he felt they still needed more time. He mentioned that Valerie had made a good point: planners must look at the whole city and emphasize where the epidemic is going. He added that the SFTF had had plenty of community input and representation from the members of the team, including himself, and he would share any information that he had contributed, as well as any information the SFTF had had available when making the decisions for the options and the slate.

Tracey added that the last few meetings had resulted in a good blend of community expertise and knowledge, as well as epidemiology. The SFTF had looked at both, to see how they could incorporate as much data as possible. The charts are available to Council members, to assist them in understanding the decision-making process. SFTF members came to these meetings with their top four priority populations, based on review of all the available data. The group then looked at those populations and had to make decisions. It was a difficult deliberation, since there are not enough resources to meet all of the needs. The group did the best that it could, looking through all of the data, and came to a conclusion on the slate as it is. She added that she had some notes, as well as the charts used, and she would provide them to anyone interested.

John stated that the groups he felt were not on the slate were: gay men (over 25) that are self identified, API, and Latino non-immigrants. Jimmie stated that the main reason he abstained from voting is because the motion is to accept the slate as is. He added that if it were refined and further defined he might go along with it, but not as is.

Ellen thanked everyone for their input, comments and concerns. As they continue the process, they will be looking at the interventions and specifics. She also thanked the SFTF for all of their work.

5. BREAK

6. CDC SUPPLEMENTAL OPTIONS DISCUSSION AND VOTE (continued):
Ellen reconvened the meeting. She informed the Council that the SFTF had talked in depth about Option 1, but somewhat less about the other two options. Option 2 is the combination of two previous options, 2&3, with the intent to create a counselor training curriculum, strategy and outreach for clients. The first piece is for a PEP campaign that would give front-line providers accurate information for their clients, inclusive of the pros and cons of PEP in a realistic sense of what it is and what regimen it requires. This would include a media campaign. The second piece is to increase STD training for HIV providers. Since, for a lot of populations, HIV prevention is sometimes not a top priority, STD prevention and encouragement of people to get STD treatment might meet more immediate needs. Someone who might say they would never get HIV might admit to having had several STDs or being susceptible to STDs. The intent is to have someone who

could develop a training program that would address both of these concerns and bring that information to providers, so that they would have the most up-to-date information. Ellen asked for discussion about this option.

Steven Sams mentioned that one of the things that is not well-documented here, but was discussed, was that these materials should be provided in multiple languages. The SFTF did not have too much time to discuss the concept of taking this work, Option 2, and finding underwriters in the corporate world. This Supplemental funding could be used to develop the materials, and with competent translations they could find corporate underwriters to duplicate the materials to make them available to different communities.

Liz referred to recent information that has come out of the AIDS conferences worldwide, that revealed that STD treatment impacts the transmission of HIV. This goes beyond the impact of treatment, into education and prevention.

Chata expressed his discomfort with the PEP component. He is in agreement with the HIV/STD part, but feels there are too many unanswered questions about PEP. He is interested in hearing how doctors and other scientists feel about the treatment. He recently read an article about a DPH grant from UCSF which may support PEP, so he would rather spend the money on Options 1 and 2. Valerie offered a point of clarification that the grant which was mentioned does not cover anything that is mentioned in this option, but rather addresses a clinical component only. Chata responded that, if they support the PEP part of this option, Council members may be assisting a project and not considering what is best for the city. He reiterated that there is not enough information about the effects, who will benefit, who can access it, etc. He does not see how PEP is going to get to those in the communities who still can't even access protease inhibitors. He believes the linkages part is good, but he is not supportive of the PEP component.

Liz stated that PEP will go forward, regardless of the support of the Council. She agrees that the concerns mentioned are all appropriate, but this option allows the Council to ensure that the community gets the information. Jimmie agreed that PEP is going to happen and providers are going to have to be careful to follow up with people who can't get it. The cost of this component should be shared with the CARE (health services) providers, since treatment should include prevention. Barbara remarked that, since PEP is new, the Council should be involved in doing something along the lines of prevention. What will clinics do if a client qualifies for PEP, and how will prevention fit into services? There is a need for a prevention piece, but the financial burden of media campaigns and correct information dissemination should be on the providers of PEP.

Ellen explained that UCSF is working with a PEP advisory board that is seeking funding to do more, but currently has money available to do prevention counseling. Jim Kahn is on 24-hour call, and if someone thinks they might have been exposed to HIV they can call him immediately. What is not happening is outreach to a broad range of communities -- specifically to community-based agencies that serve certain people who are high-risk and not in the HIV information loop. There is a lack of thoughtful discussion being conducted about how clients not exposed to HIV information will hear about PEP. There are still many unanswered questions about PEP, but what information is available must be more widespread. She stated that it is an important component to ensure that there is equality in terms of who gets good information.

Chata responded that it is important for the Council to be a part of PEP implementation, but he feels that they can be a part of it without spending the Supplemental funding on it. The Linkages Committee is already looking at consistent prevention messages as a way to be involved in it.

There just is not enough information available pertaining to the side effects or the communities that will not have access to PEP. It will be difficult to develop a training, if the basic information is not readily available. Chata reiterated that they can look at creating a consistent message without having to spend the Supplemental funding on PEP.

Jelousy asked whether the $128,000 covered the message only or included the HIV/STD piece as well. Ellen responded that it included both components, PEP and HIV/STD. Jelousy added that, as an outreach worker, it is always difficult to tell clients that something is more risky or less risky than something else. The information they give to clients can be interpreted any way the client wants; outreach must provide information with facts to back it, in order for it to be effective. If an outreach worker informs a client that oral sex is less risky, they must also explain why it is less risky. If the prevention message is clear that PEP is an option, then he is supportive of this Option 2, inclusive of the HIV/STD component. Dawn agreed with Jelousy in supporting the PEP and STD/HIV option, as long as it included both components. As an advocate for her clients, she needs to let her clients know what is available.

Maria noted that, even though the SFTF had presented these three options to the Council, they had not been approved by the SFTF with a full consensus. There were many comments made by SFTF members previous to the proposal presented today. She expressed her concern that, if people get the message about PEP, they will decide to use that instead of condoms. If providers are to address this issue of PEP, they must implement it in the right manner that will expose everyone to the information. She believes that they should always relay pertinent information about prevention, but is very concerned as to how to do that with PEP. To respond to a statement made regarding the ability to influence the PEP issue, Maria stated that, as the HPPC for the City of San Francisco, they should have the ability to advise on prevention issues, beyond recommending whether to fund or not.

Joel expressed that he is torn, because he sees that counseling does need to take place around STDs as central part of the linkages component. However, when linked to the PEP option, it becomes difficult to say which is more important. PEP cannot yet be compared to HIV counseling and prevention, in regards to determining who is at risk for HIV infection. PEP is in its earliest stages, and, although the Council needs to keep abreast of it, the information available is not sufficient enough to design an effective campaign to reach folks that might not get that information otherwise. This task would take some time to get together. He can't see spending the limited amount of funding that they have available on something that has yet to be proven effective.

Steven Sam's stated that the connection between the two components of this option is the critical piece of this concept. This connection enables the HPPC to do a major step of work for a minimal amount of money. It will also enable clinics to provide information they might not have the resources to get themselves. He added that the PEP message is in fact two messages: (1) PEP is available and, more importantly, (2) it is an option not to be used as a "morning after pill." He reiterated that they must be absolutely clear about that part of the prevention message, so people are able to make responsible and intelligent decisions.

Valerie explained that the cost may actually be less for this option. There are existing staff at STD Prevention that could increase their hours to provide these services.

Ellen stated that, to allow time for discussion of Option 3, they needed to determine if the Council was comfortable including this on the palette of funding.

A motion and a second were made to accept Option 2.

In favor:	12
Opposed:	3
Abstentions:	1

Motion carried.

Ellen introduced Option 3, to fund programs for CTRPN, lab cost only.

Liz requested confirmation on how many agencies would actually stop testing programs, due to the loss of state reimbursement for lab processing costs. Valerie responded that most agencies would continue to offer HIV counseling and testing. The problem is that the lab would not be able to process all the tests, and providers may have to decrease the number of clients they test. The intent of this option was to fund the test processing fees for the lab. Steven Sams expressed his support for this option. Because of the imminent loss of state reimbursements, drug treatment sites might be forced to stop counseling and testing.

Jimmie recommended that they change the wording under the criteria column from "...given to agencies who applied under 016," to "...given to agencies who applied **and did not get funding** under 016."

Maria referred to a comment made by Jimmie, about the cost being shared by prevention and CARE. She requested clarification as to why all the money has to come from prevention. Tracey explained that the guidelines for CARE do not allow funding for CTRPN. Ellen added that their charge as a prevention planning council is primary and secondary prevention. Primary prevention involves stopping new infections by providing interventions to both people who are negative and positive, while secondary prevention involves keeping HIV-positive people from progressing into disease. By identifying people who are positive, providers are able to get them into treatment and care earlier (secondary prevention).

Jimmie stated that the issues of primary and secondary prevention are overlapping and difficult to separate; many times providers are doing both without realizing it. Liz requested that this issue of primary and secondary prevention be placed on the agenda for discussion.

A motion and a second were made to accept Option 3.

In favor:	15
Opposed:	0
Abstentions:	1

Motion carried.

Ellen reiterated that all three options were supported, with Option 1 requiring further definition in terms of specific interventions. SFTF determined two caps for the funding options: $128,000.00 for Option 2 (2&3), $121,000.00 for Option 3, and the balance ($470,105.00) for Option 1. These are not the final figures and therefore subject to change. Specifics for the nine population categories will be provided in the application for a final vote.

Ellen summarized that, at this point, there are clear recommendations for three broad categories. The next step is for the SFTF to further define Option 1, utilizing the input and discussion from this meeting. The package will then be presented to Mitch Katz of the DPH (knowing that there is a possibility that there may be some priorities that the DPH needs to add). Once input has been received and incorporated, the application will be presented back to the Council on June 12, for a final vote. Chata recommended that they present the current slate to the DPH as soon as possible, so that the DPH feedback/input could be utilized at the next SFTF meeting, where they will be further defining the options and slate.

Point of clarification: Valerie informed the Council that she was not aware of any DPH staff considering the use of the Supplemental CDC funding, but wanted the Council to be conscious of that possibility.

Bethsaida asked for clarification regarding the timeline for the application. It was explained that the tentative timeline will be as follows:

- SFTF will meet to further define the three options and nine population categories slate.
- SFTF will then submit the options and the population categories slate to Mitch Katz.
- DPH will respond with input, which will be incorporated.
- Scope of work and budget will be mailed out to the Council members for review previous to the June 12 meeting.
- Discussion and vote, June 12 meeting.
- AIDS Office will complete the application by the June 30 deadline.

Maria inquired about the possibility of funding going to sources other than the sources specified in the application (with the specific funding options and populations). Valerie responded that in theory that was not possible; once the decision is made, the funding could not go anywhere else. She also added that it is not necessarily all of the nine population categories that will be funded. Once they have refined the interventions, it may become apparent that they will only be able to fund six of the population categories, for example.

Barbara thanked the SFTF for the tremendous amount of work that they did.

7. EVALUATION/CLOSURE

Kathleen commented on how well this meeting was facilitated, and how the Council must now prepare itself for and be considerate/aware of the 11 new members that will be joining them next month. Currently, the Council size has allowed for comfortable and effective discussions. Once the core size changes, it will become more difficult, because the dynamics will also change. She recommended that members keep this in mind, and assist the new members as much as possible.

Ellen stated that the Membership Committee had discussed how they could assist the new members' transition into active participation on the Council, by using name tags and placing new members next to veteran members. Steven Sams also mentioned that the HPPC should invite new members to the Giants Game Day. Tracey agreed that this would happen.

Maria recommended that the Council address those members that fail to attend and participate in Council meetings regularly. Members should not be allowed to miss consecutive meetings, making appearances only when their seat on the Council is threatened. Chata responded that the co-chairs are committed to reviewing attendance and will be enforcing the by-laws, inclusive of sending out letters to those members that fail to attend Council meetings.

HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for May 22, 1997

Minutes Recorded by: Amalia Fernandez-Niewendorp, Polaris R & D
Minutes Approved by: Community Co-chair Ellen Goldstein and Interim AO Co-chair Tracey Packer

HIV PREVENTION PLANNING COUNCIL MEETING

June 12, 1997
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer

Please read: **Agenda and minutes of May 15 & 22, 1997**
***Please bring*:** **Minutes, Agenda and Application for Supplemental Funding (Scope of Work)**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Food/Welcome/Introductions/Announcements	Tracey Packer	3:00 - 3:15 PM
2. Public Comment	Tracey Packer	3:15 - 3:35 PM
3. Minutes from May 15th & 22nd	Tracey Packer	3:35 - 3:40 PM
4. Break		3:40 - 4:00 PM
5. Application for CDC Supplemental Funds (Letter of Concurrence - Vote)	Chata/Ellen Goldstein and Valerie Kegebein	4:00 - 5:40 PM
6. Closure/Evaluation	Tracey Packer	5:40 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC & Committee Meetings - Thursday, June 19, 1997, 3-6 PM, AIDS Office (3rd Floor) 25 Van Ness Ave.

(HPPC will meet from 3:00 to 4:00 PM and Committees will meet from 4:00 to 6:00 PM)

HPPC Meeting - Thursday, July 10, 1997, 3-6 PM, First Unitarian Church 1187 Franklin Street (@ Geary)

HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for June 12, 1997

*** Please note in your calendar any of the following meeting times that apply to you: ***

Full-Length HPPC:	Thurs., July 10, 3-6pm at the First Unitarian Church
Linkages Committee:	Weds., July 2, 10am-12 noon at the AIDS Office
Assessment Committee:	Weds., July 2, 12-2pm at the AIDS Office
Evaluation Committee:	Mon., July 14, 9-11am at the AIDS Office
Membership Committee:	Thurs., July 24, 1-2:30pm at CAPS
Spplmntl. $$ Task Force:	Tues., July 1, 2:30-5pm at the AIDS Office

Members Present:
Barbara Adler
Ronnie (Chata) Ashley
Marcos Banales
Elizabeth Davis
Michael Discepola
Brenda Escobar
Roberto Garcia
Ellen Goldstein
Vic Hernandez
Liz Highleyman
Jelousy Jiggetts
Valerie Kegebein
Sacul L'Adnbre
Sonja Mackenzie
Askia Muhammad
Jimmie Naritomi
John Newmeyer
Henry Ocampo
Tracey Packer
J. Colin Partridge
Dawn Passar
James Rapues
Joel Reyna
María Rinaldi
Steven Sams

Members Absent:
Isabel Auerbach
Deja Dior-Britt
Kevin Gogin
Lisa Moore (excused)
Bethsaida Ruiz (excused)
Sandy Simms
John Blake West
Thomas Zickgraf

Leave of Absence
Jennifer Lorvick

Harder + Co./Polaris, Inc.:
Ellen Irie, Harder + Co.
Mary Irvine, Polaris

HPPC Process Evaluation Team:
Pali Basi
Cathleen Farrell
Raquelle Caras
Cely Quieroz
Kevin Roe

AIDS Office Staff:
Brian Dobrow
Delia Garcia
Mike Pendo

Guests:
Karen Beckerman, BAPAC
B. Lachmann (German guest)
Cynthia Laird, BAR
Loras Ojeda, MAA
Stacey Vogan, HIV PTC

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1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Welcome and Introductions

Tracey convened the meeting shortly after 3:00pm. Following the round of introductions, she gave a special welcome to new members present, and encouraged them to sit next to the veteran members, to gain clarification on any new or unclear information.

Announcements

Tracey Packer

- In response to a request from Steven Sams, Pacific Bell has made a donation of 100 tickets to the Giants game on June 20. The game is preceded by a Monkees concert at 6:00pm. Tracey asked that any HPPC members interested in this opportunity call her (554-9992) to set aside tickets for themselves and their companions.

Jimmie Naritomi

- Jimmie's program (AACAA) closed on May 30th. Jimmie noted that three of the four offices had closed entirely, but that his office (the Japanese component and administration of the program) would remain open for up to about three months. He expressed admiration for his staff, all of whom stayed through the last day of the program's existence. He added that he is still receiving many calls and will try to respond to them. In closing, Jimmie expressed his gratitude for having been able to work in the HIV/AIDS field for the past 10 years and his continued commitment, despite setbacks.

Maria Rinaldi

- Maria announced an L/G/B/T Latino Pride event taking place at the Mission Cultural Center for Latino Arts (2868 Mission St.), on June 20. The Latino AIDS Prevention/Education Team of Instituto Familiar de la Raza organized the "Mr. and Miss Gay Safe Latino 1997" event, which begins at 7:00pm. Maria invited HPPC participants to attend.

J. Colin Partridge

- J. Colin informed the group present that he would be leaving for a period of three weeks (for a conference and then vacation), but that he would be rejoining the Council afterward.

Barbara Adler

- Barbara announced that AHP is putting on a concert on June 26 at the Fillmore. She told the Council that the concert would include the Missing Man Band (featuring former members of the Grateful Dead) and Jefferson Starship. She said that tickets could be obtained through BASS ticket outlets, but that AHP also had some VIP tickets available for people who want to go backstage to spend time with the band members.

Ellen Goldstein

- Ellen notified the Council that CAPS has a position open for an administrative assistant to the Community-Based Core, to support the community research.

Chata

- Chata told the group that he would be performing on June 21 at the Women's Building (18th St. between Valencia and Guerrero) with the Two-Spirit Drum Group and eight other drumming groups. He explained that the concert will raise money to get women in the Native community to Sundance (a traditional vision-quest/spiritual ceremony), and to pay for a teepee for the women's Sundance. Donations of $2-$5 will be requested at the door.

2. PUBLIC COMMENT

Tracey introduced this agenda item by reviewing the rules for public comment. (Up to eight speakers may give comments after filling out the registration form, each speaker has three minutes and receives a 30-second warning from the co-chairs, and more time may be allowed for a single speaker if there is nobody else signed up to give public comment.) She added that the Council requests that speakers remain until the end of the period allowed for public comment, since Council members address their questions and remarks to the speakers after all public comments have been given. Tracey then gave the floor to speaker Karen Beckerman, representing BAPAC.

Public Comment

Karen Beckerman of BAPAC introduced herself as a perinatologist (a kind of obstetrician) at SFGH and the medical director of the Bay Area Perinatal AIDS Center (BAPAC). She explained that the Center was experiencing a funding crisis, and requested the HPPC's help and guidance in any of a number of areas, such as: assistance in locating funding sources, endorsement of BAPAC activities, and administrative expertise. She then called the attention of those present to the letter[1] she had distributed at this meeting, and she summarized the points in the letter describing the unique and critical nature of BAPAC's services to HIV-infected pregnant women and their families. She explained that BAPAC is the only resource in northern California offering:

- preconceptional counseling;
- counseling for newly-diagnosed HIV-infected pregnant women;
- expert care for HIV-infected pregnant women and their families;
- access to clinical trials and other scientific research;
- access to state-of-the-art HIV treatment for pregnant women; and
- expert, continuous pediatric care for HIV-1-exposed infants through 2 years of age.

Dr. Beckerman also referred to the numbers shown in the BAPAC outcomes summary attached to her letter.

HPPC Response to Public Comment

John said that he was impressed with BAPAC's outcome figures, which indicate that only three of the 49 exposed infants were infected since January 1995. Dr. Beckerman added that not all of those three infants were registered for care services at BAPAC. John said that he would like to see such results replicated in New York City (which has proportionately greater infection rates among women and infants). Dr. Beckerman responded that the results had been replicated to some extent in NYC, where the reported infant infection rate (among infants born to HIV-positive mothers) now is about 5%.

Askia inquired about the follow-up period of testing to determine whether the infants were HIV-positive. Dr. Beckerman explained that BAPAC followed the infants for about two years after birth. All of the infants were born with their mothers' HIV antibodies. While most clinics cannot determine with certainty whether an infant is HIV-infected until 1 1/2 to 2 years after the birth, BAPAC is now able to determine the infant's HIV status, with about 90% reliability, within the first 3 months after birth. Dr. Beckerman noted that the BAPAC method involves a labor-intensive testing process.

Liz asked what kind of help Dr. Beckerman envisioned the HPPC being able to provide, and she added that BAPAC might also want to approach the HSPC (the CARE Council). Dr. Beckerman replied that she had approached the HSPC, and that a great portion of BAPAC's activities fall under the rubric of education/prevention. She said that BAPAC would benefit from assistance with administration, fundraising and forming a community advisory board, as well as other areas.

Maria asked how many of the mothers (for the 50 births) had chosen to take the AZT treatment. Dr. Beckerman responded that, to her knowledge, all of the BAPAC clients had chosen to take AZT, but at different stages in their pregnancies.

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[1] to be sent with other attachments from the AIDS Office

J. Colin commented that, during the trials, one of the BAPAC nurse practitioners had looked at the reasons behind some of the women's decisions not to follow the ACTG 076 protocol. For the 18 instances of non-participation, the following reasons were given:

1) the mother did not want to be randomized (because of her perception of the beneficial effects of AZT) for the study;
2) the mother was concerned about adverse effects of AZT; or
3) the mother was restricted by her HMO or travel constraints (an issue of access).

He pointed out that BAPAC has provided *non-directive counseling* to these pregnant women with HIV.

Barbara thanked Dr. Beckerman for her work and for coming to address the HPPC. She spoke from her own experience of being close to someone who had been waiting to hear about the status of her babies. She added that she would like the HPPC to keep in mind that these kinds of situations provide incentive to keep the priority-setting model fluid. She asked that the Council think in the future about the prevention needs of these infants at risk. Dr. Beckerman added that BAPAC is also the only agency offering information on fertility and safe sex.

Sonja asked about the effectiveness of combination therapy. Dr. Beckerman responded that, for every client who has chosen it (about one-half of the clients are taking aggressive triple combination therapy), the viral load has been brought down to undetectable levels in the mother and the infant has been uninfected. Dr. Beckerman said that the labor and delivery care for these women is very difficult, and that they benefit from the experience and expertise of the BAPAC staff. She noted that all the answers are not yet in.

In response to a question from Jelousy about how much funding had been cut from BAPAC. Dr. Beckerman responded that the program was first cut by 25%, but then suffered an additional 38% cut. She said that about $70,000 in additional funding would bring the program back to its original levels, but that less money than that would be needed to keep the program functional. She explained that BAPAC is a relatively small operation. (See the letter for information on the specific staff positions and services for which BAPAC is currently seeking alternative funding sources.)

Jimmie asked if the infants had been followed sufficiently to determine (1) the side effects of the mother's drug therapy, and (2) the number of infants seroconverting later. Dr. Beckerman replied that the data available are only for AZT monotherapy. She explained that the infants born to mothers who have undergone AZT monotherapy are born anemic, but that this condition ends with the termination of the AZT therapy for the individual infant. Encouraging safety data are also available from Africa, although it is difficult to compare safety data from the third world (especially on infants) to data in this country. Dr. Beckerman added that one study of twelve babies suggests that protease inhibitors are also safe for perinatal treatment. Regarding later seroconversion, Dr. Beckerman explained that this is mostly seen in third world countries, and has been linked to breast-feeding by HIV-positive mothers. It has not yet been reported in the U.S.

Chata said that he felt the Council should write a letter of support for BAPAC. He added that he had started out working in pediatric AIDS, and that he thought BAPAC's services should be considered for prevention funding.

Tracey noted that **the Council could write a letter, and/or the co-chairs could consider, with input from the full Council, additional ways to support the work of BAPAC in the future.**

A motion was made for the co-chairs to consider how the Council could support BAPAC (including the writing of a letter of support). With one abstention, consensus was reached among those present, so **the motion carried.**

Jimmie offered this point of clarification regarding voting privileges: New members, who are attending in June and July, will not actually start voting until August 1.

3. MINUTES FROM MAY 15TH AND 22ND

Tracey explained that the minutes of 5/22 had not yet been mailed, but were distributed at this meeting to all members present. She first asked if anyone had questions or comments/corrections on the minutes.

Regarding the minutes of 5/22, John stated that the fourth paragraph on page 9 should read: "John stated that the groups he felt were not on the slate were: gay men (over 25) that are self-identified, API, **or** Latino non-immigrants." This substitution of "or" for the word "and" was accepted into the record.

With the change mentioned above, the minutes of 5/15 and the minutes of 5/22 were submitted to a vote for approval. Of those present, 12 members voted in favor of approval and 4 abstained. **The minutes were thus approved by consensus.**

4. EXPLANATION OF TASK TO FOLLOW BREAK, AND FAREWELL TO MARY

Background for the Supplemental Funding Vote

Ellen stated that the Council's primary task for this meeting was to vote on the AIDS Office Application for Supplemental CDC Funding. She introduced this work with a reminder of the context of the decision. She explained that, at the end of each year, the CDC looks at how much funding it has available to allocate, and applies a formula to determine the amount of funding for which each city jurisdiction can apply. This Supplemental funding is not automatic; each city is expected to determine its own priorities and to submit an application which addresses them. Ellen reported that the SFTF had been examining the gaps in funding for San Francisco, and had created a list of priority areas for presentation on May 15th and a vote on May 22nd. This meeting constituted the last opportunity for the HPPC to approve the priorities in the application, which would be due on June 30. If a majority vote or consensus could be reached at this meeting on the priorities, then the HPPC would submit a letter of concurrence, without which the CDC cannot consider the application complete. Ellen stated that the results of the latest SFTF meeting would be presented after the break.

Recognition of Logistical Support Staffperson

Chata said that he would like to recognize Mary for her work with the Council over the past two years. He read a letter of thanks and recommendation from the HPPC co-chairs, which was then presented to Mary along with gifts and a cake from the co-chairs. Mary was happily overwhelmed, and looks forward to using her engraved HPPC Cross pens at Columbia, where they will make her the envy of her fellow students.

-- BREAK --

5. APPLICATION FOR CDC SUPPLEMENTAL FUNDS (Letter of Concurrence -- Vote)
Ellen and Chata presented on the SFTF recommendations. Ellen began by explaining that the SFTF had been charged with setting priorities for the allocation of the Supplemental CDC funding. She named the SFTF members (Askia, Sacul, Maria, Liz, Jelousy, Joel, Steven, Ellen, Chata, Tracey, Mike P., Valerie, and Brian), who had devoted numerous hours over the past two months to examining local prevention gaps and feasible options for remedying them. At the break, a goldenrod sheet[2] with proposed interventions for priority BRPs (described in more detail by specific co-factors and covariates) had been distributed to those present. Ellen reviewed the three main funding options recommended by the SFTF (and introduced at the meeting and in the minutes of May 22):

- **Option 1** -- Fund **unmet service needs.** (See specific populations listed on the handout.)

- **Option 2** -- Fund a prevention education and training curriculum for providers on (a) PEP and (b) linkages between HIV and STD education, as well as protease inhibitors and primary and secondary prevention.

- **Option 3** -- Cover the de-funded lab costs for CTRPN.

In the meeting on May 22, the Council requested that the SFTF refine the list of unmet needs to be included for potential funding under Option 1 (i.e., explain which populations have needs for which interventions). Ellen reviewed that the SFTF had identified nine priority client populations, after considering the following factors:

- gaps in funding;
- comparison of prevalence to funding levels;
- BRPs (size and prevalence);
- incidence; and
- co-factors.

The BRPs (with defining co-factors and covariates) were then grouped into the four highest-priority populations and five high-priority populations.

Tracey explained that, in the newer set of eight priority populations, the Native American MSM and MSM/F that had been in the eighth population were included in the third (previously the fifth) population (Native American and African American MSM and MSM/F). This left a list of eight priority populations with unmet service needs, which was included in the draft AIDS Office application. The four highest-priority populations from the previous list remained highest-priority in the newer list of eight.

Ellen read through the highest-priority and high-priority population descriptions on the goldenrod handout. She noted that the SFTF had, on the Council's request, narrowed down the interventions needed by each priority population. In the goldenrod handout, these interventions are listed by client population.

Ellen noted that the SFTF had been approached by Dr. Mitch Katz, who offered three proposals for the allocation of the Supplemental CDC funding:

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[2] to be sent with other attachments from the AIDS Office

1) **SOS/ICHO** -- restoration of funds to street outreach program which received a lower level of funding (than the previous level) through the 1996 RFP process;
2) **NTFAP local programs** -- restoration of funds to programs which lost CDC Direct funding; and
3) **De-tuned Assay** -- looking at frozen, stored blood from persons who tested positive, to determine whether those people seroconverted within a 126-day period prior to the test. This last project would allow for a determination of the number of recent infections (incidence), from among the infections discovered in HIV testing.

Ellen reported that the SFTF had elected to continue in the direction it had been taking (with the approval of the Council). Rather than focusing on specific agencies and programs, the SFTF decided to continue pursuing its focus on underserved populations and appropriate interventions for them. She pointed out that some of the populations would fit within the groups targeted by NTFAP programs and/or SOS. In this sense, the SFTF priorities may indirectly address those de-funded programs. However, the SFTF agreed to leave the agency-specific funding decisions to the DPH. Ellen noted that the SFTF had also decided not to entertain the third proposal (de-tuned assay). She explained that the group had received information suggesting that the HPPC may be able to find other funding for that project.

Ellen described the SFTF process as one which reflected an interesting combination of community/ provider expertise and epidemiological data.

Discussion

In response to a question from Jimmie, Ellen explained that the SFTF was bringing back the recommended *interventions* for Council feedback and modifications, but that the priority populations had already been accepted by a majority Council vote on May 22. Maria said that she had understood the May 22 vote to be only a concept vote. Ellen clarified that the May 22 vote had been final. A concept vote was taken earlier on the SFTF work, at the May 8 Council meeting.

Roberto asked, regarding the ICHO/SOS de-funding, if he was correct in understanding that those funds for street outreach services had still been available, but had been awarded to other agencies. Ellen explained that the funding for street outreach had been redistributed, and that ICHO had not received the amount it had been awarded in the previous allocation process. After an appeal was made to the DPH by ICHO/SOS, some of the agencies which had participated in the SOS collaboration were given funding to re-hire community health outreach workers (CHOWs).

Joel expressed concern that not everyone had been aware that the May 22 vote was final. Ellen said that she understood his concern, but that a final vote could not be changed simply because somebody had not recognized that it was final (concept votes are noted as such on the agendas).

Maria asked if the order of priorities under Option 1 (unmet service needs) had also been set. Ellen responded that the top four (highest-priority) had been selected, but that the priorities had not been ranked *within* the highest-priority or the high-priority groups. Liz added that the priorities might not be funded in their current order, since that order does not actually represent a ranking from 1-8. It is also not clear how many of the populations can be addressed with the Supplemental funding, because that will depend on how much it costs to augment current contracts or fund new programs.

Interventions Chosen for the Priority Populations

Chata read through and briefly described the types of interventions that the SFTF had recommended for each of the 8 priority populations. For example, for the first population shown, he explained that the SFTF had agreed that interventions should be designed by and for youth, and should be engaging and event-focused. In the second group, the defining factor was speed use, so the SFTF prioritized mobile interventions that can reach speed users in the appropriate venues and neighborhoods, with flexible hours to meet clients' clubbing schedules. Regarding the population of FSM (women of color and with risky male partners), Chata explained that a needs assessment had already been scheduled for 1997, and that none of the Supplemental funding would need to be allocated for the assessment. The Supplemental funding would go to provide 1998 services to meet needs identified in 1997.

Discussion

Prevention for API IDUs

Roberto asked if there was a reason for not including APIs in the priority IDU populations. Chata replied that the SFTF had identified service gaps for Latino, Native American and African American IDUs, but not for API IDUs. Ellen added that the group had looked at where the funding had gone and had compared the funding levels with the rates of prevalence and incidence in the IDU populations. Roberto remarked that he thought the API population should be included, specifically under this category for IDU populations.

Consideration of Efficacy of Interventions

J. Colin asked how the SFTF had arrived at the list of priorities, and whether it was based on needs or on what was most likely to be efficacious. Ellen explained that the SFTF had based its recommendations on a review of both needs and effectiveness. The SFTF used a chart of the current funding by BRP, race/ethnicity and intervention. From that information, the SFTF could see, for example, that API MSM-IDUs have 21% of the funding that targets MSM-IDUs -- disproportionate to the percentage (10.5%) of APIs in the MSM-IDU population overall. Ellen stated that the SFTF had also considered how the population was most likely to access or be reached by prevention information. Some populations would require more initial outreach and exposure, while others would require a focus on progressing from awareness to significant behavioral change.

Correction -- IRRC

Jimmie pointed out that the key at the bottom of the handout should be corrected to state: "**individual** risk reduction counseling = IRRC." **This correction was noted.**

Prioritization of Populations for VBIO

Regarding VBIO, Jimmie expressed concern that existing programs already target the first seven HPPC-ranked BRPs, and that the three priority populations for which the SFTF was recommending VBIO also rank high within those top seven BRPs. Jimmie also asked, for the gap identified for speed users, whether the population would be targeted more specifically by neighborhood or some other means (since speed users of all ages and ethnicities were being prioritized). He asked if the SFTF had found that speed users as a whole were underserved. Ellen explained that:

(1) No programs specific to speed use had been funded under RFPs 015 and 016-96;

(2) Native American MSMs were found to have low funding for VBIO and no funding for confidential CTRPN, so the SFTF had decided to prioritize VBIO which would link to other services such as CTRPN; and
(3) VBIO was identified as a useful intervention for bringing services to places where people are already engaging in help-seeking behaviors (e.g., IDUs at needle exchange sites).

Jimmie said that he would have expected that all of the programs currently providing VBIO and claiming to serve IDUs would have to be working with Prevention Point (the local provider for needle exchange). He stressed that VBIO providers should be at needle exchange program (NEP) sites, if they aren't already. He was puzzled to learn that VBIO for IDUs would still qualify as an unmet need of the highest priority.

Specific Questions on the First, Second and Fifth Unmet Needs Areas
Jimmie then mentioned some more specific questions he had about the SFTF recommendations:

#1) Regarding the priority of queer-identified youth of color, Jimmie said that he understood the need for prevention to Native Americans, and did not know which of the funded programs had claimed to serve African Americans. However, he understood that MNHC had been funded for a gay Latino youth program, under CDC RFP #704. Valerie explained that the MNHC program had been considered by the SFTF, but that it only targets youth under 18. Ellen and Chata clarified that the HPPC Plan defines youth as persons under the age of 25. Thus, a gap would still remain for queer-identified Latino youth between the ages of 18 and 25. Jimmie requested that the language of this priority be revised to specify that the funding should cover African American and Native American youth, and Latino youth ages 18-24. **This correction was accepted into the record.**

#2) Regarding the NE recommended for the second priority population in the handout, Jimmie asked whether a new needle exchange might be funded or whether more funding would simply be added to the existing NEP. Steven explained that this priority would not necessarily entail funding additional needle exchange work. It could just mean that interventions for speed users would be made available at needle exchange sites. Ellen stated that the SFTF actually had discussed the possibility of setting up new NEP sites, since there are two main types of NEP clients, and more NE is needed for the gay-identified, club-oriented client population. Jelousy added that the SFTF had intended to cover both the speed users who inject and those who do not. Ellen noted that the recommendations for how these priorities should be implemented would follow in the next stage of work on the Supplemental funding allocation. She asked the group present to focus on the issues at hand for the current vote (not related to implementation).

#5) Regarding FSMs with risky partners, Jimmie noted (1) that "women of color" constitutes a broad category, and (2) that Westside Women's HIV Prevention Services was the only program which had been funded specifically to serve women (and he wondered how the task force would consider that issue). Chata responded that the decisions about which interventions to fund for FSM would have to be based on the results of the 1997 assessment. Ellen explained that the SFTF had considered the need for linkage of HIV prevention services with women's shelters, women's health and perinatal care programs, and other places where it would be feasible to provide prevention services to women who might not recognize their own risk (because their risk stems from unacknowledged risk

behaviors of their partners). She said that the implementation phase would have to include some planning for how to get into non-traditional HIV prevention venues.

In response to a question from Jimmie about whether the three providers funded under CDC #704 had been taken into account, the co-chairs affirmed that that information had already been assimilated into the SFTF discussions.

Correction -- MSM Belong in #8
Steven asked about the dropping of MSM from the eighth priority population (which had been created from a combination of the eighth and ninth populations in the original list). The co-chairs noted that this omission was unintentional, and **agreed to make a correction to add MSM** back into that priority population (MSM/F, MSF and MSM -- Latino, immigrant, and migrant indigent, including transgendered population, with other co-factors).

Effectiveness of Newer Intervention Types
John asked about the efficacy of the interventions recommended, and whether the SFTF had weighed efficacy for all or only for some. He noted that some interventions in the range recommended are well-proven, while others (e.g., MSGs organized around theater or writing workshops) were more innovative and relatively untried. Chata and Ellen explained that efficacy had been considered for all of the interventions. Ellen reported that some initial evaluation work had been done in Seattle on these newer types of MSGs (workshop or coffeehouse-style). Bob Hayes and Susan Kegeles had performed some efficacy studies which demonstrated the effectiveness of these MSGs with non-traditional formats. John commented that the Council should remain open to the possibility that some of the interventions may not work as expected.

Atomization of the Supplemental Funding
John then noted that the Supplemental funding ($719,105) would not even cover the salaries of 20 individual FTEs, much less the roughly 20 separate programs suggested in the handout. He stated that the funding would only be able to function as part of a staff person's time in each program. Pointing to the "atomization" of the Supplemental funding into so many priorities, he reminded the Council not to think too grandly about what could be accomplished in any individual area. Ellen responded that some of the funding could be used to augment existing contracts, while some of it might go into RFPs. She stressed that it was not guaranteed that all of the priorities identified would be funded. She added that the Council would also be looking at criteria for reviewing the proposals to be submitted. She agreed with John that it would be unreasonable to expect to meet all of the needs outlined in the handout.

Prevention for Female Populations
Maria apologized for not having made her comment at the last meeting, when she was under the impression that committee members could not raise questions in the full Council about the work of their committees. She expressed her extreme disappointment and frustration with the outcome of the SFTF process. She explained that, last year, providers serving women and doing VBIO addressed the Council after the release and results of RFPs #015-96 and #016-96. The Council had at that time expressed agreement with the public about the gaps in service for women, and particularly for women of color. She was upset by the SFTF slate of populations, which she saw as leaving the same kinds of gaps in service for female populations. In her understanding, it was unwise to base prevention planning on HIV prevalence rates in a location. She explained that San Francisco has a very different HIV epidemic from the epidemic elsewhere, and that many people

from other places are moving into and through San Francisco, influencing the epidemic here in ways that might eventually cause it to resemble the more common pattern in other cities (i.e., more infections among women who were at risk from their male sexual partners). She stressed that the Council last year had agreed that BRPs 8-12 were underserved, and she asserted that they would still be underserved with the current slate of populations for Supplemental funding Option 1.

Maria went on to say that it seemed wrong to her that the FSM group (risky partners, women of color) was identified as the only population under Option 1 that requires an assessment of needs. Regarding the SFTF process, Maria said that people on the committee had made suggestions for the approaches to be taken to different populations, and that a different group of people could have come up with a different set of recommended interventions to address unmet needs. She also asked why the Council had not been presented with an analysis of the results of the Delta Study (of women who have sex with MSM/Fs), which may elucidate the prevention needs of these women.

In closing, Maria said that the HPPC cannot simply blame the AIDS Office for underserving women, given that the HPPC has chosen again to prioritize other populations for prevention. She then referred to the concerns raised by Dr. Beckerman about the cuts to BAPAC's services, and said that letters of support from the HPPC are not enough to keep people from becoming infected.

Chata responded to Maria's comments by saying that, when the Council and co-chairs addressed the Health Commission and sent a letter of concern to the CDC (with the AIDS Office Cooperative Agreement Application), they pointed to gaps and problems in the overall process -- and not just around the underserving of women. He added that the Council has been faced with a difficulty around how to put funding into prevention for a population that doesn't show up significantly in local prevalence and incidence data. He said that he wanted to validate Maria's feelings and concerns, and that the Council is still facing this question of how to address the prevention needs of a population that doesn't (in the available data) appear to be at immediate risk for HIV.

Ellen stated that the Council had wanted to address the women at greatest risk for HIV. One of these populations is the group of women who inject. She reviewed that, in San Francisco, 4% of those infected with HIV are women, and this percentage has been quite constant over the past five years. Ellen said that the other group of San Francisco women (non-injecting) at risk for HIV consists of women with risky partners. These women might not seek out prevention services, because they often don't know of their own risk. Ellen explained that this was the reasoning behind the SFTF decision to prioritize these two specific groups of women for Supplemental funding.

Chata added that the co-chairs hope that a presentation on the findings of the AIDS Office Delta Study will be made to the Council in the near future (by July, if possible).

From the most recent epidemiological Consensus Meeting (May 12, 1997), John offered the following estimates on the people in San Francisco infected with HIV *this year* (as opposed to prevalence, which refers to all existing infections):

⇒ Females make up 14% of the people infected with HIV this year.
  → 8% of all those infected this year are female IDUs; and
  → 6% of all those infected this year are females infected through heterosexual activity.

John noted that, while this estimate suggests a higher proportion of women getting infected now with HIV, he would still want to spend about 6/7 of the available prevention funding on services to males (since males still make up about 86%, or 6/7, of the new infections in San Francisco).

(Note: Subsequently, Kimberly Page Shafer of the Seroepidemiology and Surveillance Branch of the AIDS Office submitted the following preliminary Consensus estimates:

- *Heterosexual Female IDUS*
  - *Prevalence -- 10%*
  - *Incidence -- 1.0%*
- *Heterosexual Female non-IDUs*
  - *Prevalence -- 0.25%*
  - *Incidence -- 0.01%*

Further discussion of all the Consensus estimates will be brought to the Council -- probably in July.)

Ellen pointed out that, currently, *31%* of prevention funding in San Francisco is targeting programs focusing on women. The proportion of funding for women is already higher than the proportion of new infections among women.

Barbara stated that she feels the Council is doing a lot of good for the distribution of prevention services in San Francisco. She said that all of the Council members have some issues about the amount of funding available for the populations they represent. Barbara noted that the category of women at risk solely through their risky partners (the fifth priority population listed on the goldenrod sheet) encompasses a large number of women, who could then benefit from prevention services targeting that category. Barbara also pointed out that one way of addressing the risk of women is to target their risky male partners (such as closeted MSM/Fs) with prevention services. She said that it reassures her to realize that the priorities that do not directly target women are at least targeting their male partners, and are thus still doing a service to women. She closed by saying that the Supplemental funding priorities are covering areas that were not funded in 015/016.

Sonja thanked Maria for her comments. She said that she, too, was disturbed by the suggestion that only women are still in need of an assessment. She was also confused by the claim that no funding would be going into that priority for this year. Ellen said that Valerie could clarify the funding for each year, since the funding and service cycles are not easy to explain. Sonja said that AIDS deaths and HIV incidence among women are both rising, and she found it upsetting that there had not yet been an assessment to determine the prevention needs of women. She then asked if age was a defining factor for the FSM category, and was informed that category includes women of all ages. Sonja said that she would advocate for more attention to the risk of *young* women.

Barbara obtained clarification from the presenters that the FSM assessment would involve an assessment of the gaps and where/how to target that population.

Sonja asked whether the SFTF had also discussed non-IDU FSF/M as a priority population. Ellen responded that that population had not been considered a high enough priority (according to the SFTF criteria mentioned earlier) to be incorporated into the list of 9 populations (now 8). Valerie reiterated that the SFTF had reviewed a whole set of data on where the existing prevention funding had been allocated. The group's discussion focused on the remaining gaps in funding. Steven and Ellen added that the list of 8 populations represents only the highest priorities among many gaps.

Prevention for Heterosexual Males

Marcos said that he had worked in HIV prevention for many years, and that he was now working mostly with straight (heterosexual) people. He said that he had not seen any funding directed at

prevention for straight men in SF. He explained that non-IDU straight men often do not use condoms and are getting infected with HIV. He requested some figures and other information on the services available for this population. Mike Pendo of the AIDS Office responded that the estimated prevalence in the population of **non-IDU** heterosexual men is .09% (less than one-tenth of one percent). He added that the population size is about 252,544 men in San Francisco. The majority of the local programs serving the population are focused on youth. Mike added that there are 4-5 programs targeting this BRP (BRP #11), and one is targeting just incarcerated men.

Interventions for MSM/F Who Do Not Self-Identify as Gay or Bisexual
Referring then to the prioritization of media (M) as the sole intervention to be funded for the non-gay/bisexual-identified MSM/F population, Marcos asked whether the media would include more contact-oriented approaches than simple billboards. He said that people in this group seem to need the kind of contact and active engagement offered by discussion groups. Chata responded that the SFTF had not yet been able to get into the details of the types of interventions to be implemented. Ellen told Marcos that the SFTF had been under the impression that non-bisexual/gay-identified MSM/F would be unlikely to attend a group to discuss their same-sex behaviors. For this reason, media was identified as a means of communicating the prevention message to such men, who behave bisexually outside of a gay or bisexual community context. She stated that the SFTF would still be interested in hearing Marcos' ideas on how to effectively target discussion groups to meet the prevention needs of this population.

Support for Earlier Comments (esp. re: FSM risk)
Askia said that he wanted to affirm the comments of Council members regarding the SFTF work, and to invite more people to serve on this challenging committee. He expressed support for Maria's points about needing to target FSMs. Due to his experience with the rates of STDs in the non-IDU FSM population, Askia was surprised to find the HIV seroprevalence rates so low. He questioned the idea of waiting for the education of men to make women safer from HIV infection.

Venues for Targeting Speed Users
Roberto asked why the interventions for speed users should only target the Tenderloin. It was clarified that bars and clubs outside of the Tenderloin would also be targeted, and Chata added that the interventions would include speed users who don't frequent bars and clubs.

Budget
Valerie presented a handout on the budget for the AIDS Office Application for Supplemental Funding[3]. She first recapitulated that the infrastructure of the AIDS Office would need to be augmented in order to manage any new or expanded contracts resulting from the Supplemental funding. The anticipated administration costs were included in the budget for the application. Valerie then named three options for funding the priorities:

1) Augment existing contracts --
   a) with more funding, or
   b) by expanding their scopes of work;

[3] to be sent with other attachments from the AIDS Office

2) Look at the proposals (good for up to one year) submitted earlier but not awarded funding, and consider why they were not funded and whether they might address some of the prioritized unmet needs; and/or

3) Issue a new RFP.

Valerie clarified that the Council was currently deciding on the priorities and application for funding that would be made available to San Francisco in 1997. She briefly noted that the budget includes $6,000 for PEP/STD training materials and supplies, $121,181 for HIV testing lab costs, and $512,583 for interventions for unmet needs (although it is not yet clear how many or which of the priorities that will cover). Valerie added that the CDC has provided some assurance that the 1997 Supplemental funding can carry over and be used in 1998. She explained that it would be unrealistic to expect to hire new AIDS Office staff before the last four months of the year (Sept.-Dec.). For the STD City Clinic position (Option 2), the funding would simply be used to expand the duties and hours of an existing health educator. Valerie added that the AIDS Office was considering purchasing two FTEs for PEP counseling, to cover different sites and neighborhoods. The target sites are being identified by the PEP community advisory group working with Dr. Katz.

Valerie added that the implementation steps for getting out the funding had not yet been determined.

Budget Discussion
Jimmie asked about the variance in fringe benefits for DPH employees. Valerie explained that the differences in benefits stem from different civil service classifications and different unions.

Barbara gained clarification that the funding for the health educator position will go to City Clinic.

Valerie explained to the Council that the AIDS Office will apply for the base award and another $719,105 in 1998. Since there is likely to be the same amount of Supplemental funding available in 1998, it would be advantageous to spend this 1997 Supplemental funding as quickly as possible. Ellen added that, between the two sets of Supplemental funding (1997 and 1998), the Council hopes to be able to address all of the prioritized unmet needs. Steven asked whether the funding for CTRPN lab costs could also be re-used in 1998, and Valerie responded in the affirmative.

Voting
Chata explained that the HPPC would first be voting on the *interventions* proposed for the priority populations (goldenrod sheet), and would then vote on the *letter of HPPC concurrence* with the AIDS Office application (including the budget, etc.).

Maria stated that she was unsure of the basis for the HPPC vote, given the lack of clarity around which populations would receive funding. Ellen explained that the HPPC would be voting on whether the SFTF-recommended priorities for interventions by population type should go into the application to the CDC. She added that part of the letter of concurrence could be used to stipulate that the Council will further prioritize/rank options within the top four and the remaining four unmet needs, and will also explore options for funding the priorities. She suggested that the letter of concurrence could be made contingent upon the continuation of the collaborative process between the SFTF, AIDS Office and full Council -- for decision-making on the implementation steps to move forward.

The motion was made to approve the priorities for the application with the three corrections mentioned above (IRRC in key, inclusion of MSM in the eighth population group, and clarification of Latino youth ages 18-24 in the first population group).

The Vote (with a quorum of 14 voting members present):

In Favor:	**10**
Opposed:	**1**
Abstentions:	**3**

The motion carried.

Application to the CDC

Ellen presented the structure of the AIDS Office Supplemental Funding Application to the CDC[4]:

- **I.** Abstract
- **II.** Background and Need for Support
- **III.** HPPC Involvement in Application Preparation
  - Options 1-4 (PEP and HIV/STD training appear as separate but linked options.)
  - Slate of prioritized populations under Option 1 (unmet service needs)
- **IV.** Scope of Work -- including the additional objectives under HE/RR (health education and risk reduction)
  - Objective 1: for a collaborative HPPC/AIDS Office Implementation Task Force to proceed with implementation tasks (review of existing contracts, proposals , etc.).
  - Objective 2: for the implementation of the approved interventions for priority populations identified under Option 1.
  - Objective 3: for the finalization of 1998 contracts to meet the Supplemental needs.
  - Objective 4: for expansion of the MOU between the STD City Clinic Prevention Unit and the AIDS Office Prevention Planning Unit, to include PEP training.
  - Objective 5: for collaborative (AIDS Office and STD City Clinic) development of a provider training curriculum on PEP and STD prevention.

Chata pointed out that the activities and evaluation steps shown under each objective describe some of the checks and balances being put into this application, to ensure collaboration and involvement from the HPPC in the implementation of the Supplemental funding priorities.

Tracey suggested that any corrections to the grammar or punctuation of the application be submitted to Brian Dobrow.

Jimmie made the following comments:

- On page 1, make reference to the fact that, in the process of identifying unmet needs, the SFTF also looked at the distribution of CDC Direct funding.
- On page 2, break out the estimates for young men under the age of 25, specifically.
- On page 3, strengthen the explanation of the need to pay for lab costs (i.e., because the state reimbursement for certain lab costs was lost -- leaving CTRPN services covered, but not the lab costs for test processing).
- On page 6, carry over the correction of RRC to IRRC into this application.

[4] to be sent with other attachments from the AIDS Office

- On page 7, clarify who is doing the evaluation for Objective 2.
- On page 7, clarify what the Assessment Committee is doing (other than receiving a report), for the evaluation of Objective 3.
- On page 7, clarify who is doing the evaluation for Objective 4.
- In general, check on and specify the titles for the particular units of the City Clinic, where they are mentioned.

Barbara asked for clarification on whether the CTRPN lab funding (page 6) would only be intended to cover the costs for those agencies which lost their state funding, or whether there would be an open process to allocate this money. Ellen confirmed that the funding would cover lab costs of those which had been de-funded by the state. Valerie added that, if those testing sites do not submit enough lab costs, other lab costs could also be covered with that funding.

The motion was made to send a letter of concurrence with the application, as corrected above.

The Vote:

In Favor:	**13**
Opposed:	**0**
Abstentions:	**1**

The motion carried.

6. CLOSURE/EVALUATION

Kevin congratulated the Council on its accomplishment of this decision-making task. He reminded members that they have every right to express their opinions in this meeting setting. He added that it is important for new people to ask their neighbors questions of clarification, so that they can fully follow and participate in the discussion. He added that he hopes that old and new members will continue to sit next to each other over the course of the year.

It was announced that the immigrant amnesty bill and petition (announced at the last meeting by Maria) had been brought to this meeting, for members to review and sign. Chata said that the Council would probably also be drafting a letter of support for the bill. Maria reminded members of the role of recent immigration as a co-factor in the HIV epidemic. She expressed her sense that any measure taken to improve the condition of immigrants will also assist in stopping the spread of HIV. The co-chairs agreed that copies of the bill, along with a list of the agencies which have already supported it, would be sent to the full Council membership. The topic would then be placed on the agenda for a vote at a future Council meeting. (Note: This vote will take place on July 10.)

Distributed at This Meeting:

- Dr. Karen Beckerman's letter to the HPPC, requesting support and guidance for BAPAC;
- "Supplemental Funding Task Force Proposed Interventions for Priority BRPs;"
- "CDC Cooperative Agreement Application for Supplemental Funding -- **Budget**;"
- "CDC Cooperative Agreement Supplemental Funding Application;" and
- "Participant Dialogue" boxes and "Evaluation Results" from the May 22 meeting.

Minutes Recorded by: Mary Irvine
Minutes Approved by: AIDS Office Co-Chair Tracey Packer and Community Co-Chair Ellen Goldstein

HIV PREVENTION PLANNING COUNCIL MEETING

June 19, 1997
3:00 PM to 6:00 PM
AIDS Office
25 Van Ness Avenue (Room 330A)
San Francisco

Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer (interim)

Please read: **Agenda**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Food/Welcome/Introductions/Announcements	Chata	3:00 - 3:10 PM
2. Member Orientation (Exercise)	Ellen Goldstein	3:10 - 3:50 PM
3. Technical Support to the Council	Chata/Ellen	3:50 - 4:05 PM
4. New Member Committee Assignments	Chata	3:0● - 3:10 PM
5. Break		4:10 - 4:15 PM
6. Committee Meetings		4:15 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC & Committee Meetings :

Thursday, July 10, 1997, 3-6 PM, First Unitarian Church - Franklin & Geary Streets

Thursday, July 24, 1997, 3-5 PM, First Unitarian Church - Franklin & Geary Streets

NOTE: Each Committee is responsible for scheduling its own meeting time(s) and days

HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for June 19, 1997

*** Please note in your calendar any of the following meeting times that apply to you: ***

HPPC:	Thurs., July 10, 3-6 p.m. at the First Unitarian Church
	Thurs., July 24, 3-5 p.m. at the First Unitarian Church
Linkages Committee:	Weds., July 11, 9:30-11:30 a.m. at the AIDS Office
Assessment Committee:	Weds., July 17, 4-6 p.m. at the AIDS Office
	Thurs., July 31, 4:30-6:30 p.m. at AIDS Office
	Mon., Aug. 11, 4:30-6:30 p.m. at AIDS Office
Evaluation Committee:	Mon., July 14, 9-11 a.m. at the AIDS Office
Membership Committee:	Thurs., July 24, 1-2:30 p.m. at CAPS
R & R Task Force:	Weds., July 23, 9:30-11 a.m. at AIDS Office

Members Present:
Barbara Adler
Ronnie (Chata) Ashley
Marcos Banales
Elizabeth Davis
Michael Discepola
Ellen Goldstein
Vic Hernandez
Valerie Kegebein
Sonja Mackenzie
Askia Muhammad
Jimmie Naritomi
John Newmeyer
Henry Ocampo
Tracey Packer
J. Colin Partridge
Dawn Passar
James Rapues
Joel Reyna
María Rinaldi
Bethsaida Ruiz
Steven Sams
John Blake West
Thomas Zickgraf

Members Absent:
Deja Dior-Britt
Brenda Escobar
Kevin Gogin
Liz Highleyman
Jelousy Jiggetts
Sacul L'Adnbre
Lisa Moore
Sandy Simms

Leave of Absence
Jennifer Lorvick

AIDS Office Staff:
Brian Dobrow
Delia Garcia
Mike Pendo

Guests:
B. Lachmann (Germany)
Christopher Smith, Brothers Network
Stacey Vogan, HIV PTC

Harder + Co./Polaris, Inc.:
Amalia Fernandez-Niewendorp, Polaris, Inc.
Marty Forst, Polaris, Inc.
Mary Irvine, Polaris, Inc.
Lyn Paleo, Harder + Co.

HPPC Process Evaluation Team:
Pali Basi
Ruel Caneda
Raquelle Caras
Cely Quieroz
Kevin Roe

1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Chata convened the meeting shortly after 3:00 p.m. and asked that members and guests introduce themselves. He welcomed everyone and asked if there were any announcements.

Announcements

Tracey Packer

- Distributed 2 page handout - information and registration form - for the STD Control Program - STD Education Unit training workshops. The next workshop will be July 1 & 2, and the cost is $20 per person.

- Giants vs. Dodgers tickets are still available for the game tomorrow evening. She will distribute them after the meeting, during the break.

Maria Rinaldi

- Distributed letter dated 9/13/96 to Mitch Katz from the HPPC Co-Chairs, pertaining to the need for HIV prevention services for women. Gives context to her comments from the last Council meeting.

Delia Garcia

- Distributed brochures for the 2nd National Harm Reduction Conference which will be held next year, in Cleveland, Ohio.

- Distributed 2 page handout - information and endorsement form - for the National Coalition to Save Lives Now! They are trying to lift the federal ban on needle exchange. Delia encouraged members to read and endorse it and fax to Latino Coalition on AIDS in New York. *Chata added that the co-chairs will be discussing this matter at their next meeting.*

Valerie Kegebein

- Flyers available for the documentary "Follow Me Home" at the food table. She explained that she had recently seen the documentary and felt that it would be something the Council members could benefit from. Chata added that he too had seen the documentary and agreed on the potential value of seeing this very powerful film about multiracial issues.

Kevin Roe

- A personal comment was left out of the Participant Dialogue boxes distributed, instead the comment forwarded to the person to whom it was directed.

- For the sake of new members he gave a brief explanation of the purpose of the Participant Dialogue boxes. At each Council meeting, blank Participant Dialogue boxes are distributed to list any comments or constructive criticism pertaining to either the Council members, co-chairs, AIDS Office staff, Consultants, (i.e. Harder + Co. and Polaris), or the Evaluation Team. We ask that respectful tones be used by all respondents. The intent of the Participant Dialogue boxes and the Meeting Evaluation forms is to help the Council work better.

Steven Sams

- Distributed flyer of UCSF AIDS Health Project's "Building Hope Benefit Concert". The concert is scheduled for June 26, 1997 at the Fillmore.

2. PLANNING SUPPORT CONTRACT UPDATE

Chata explained that the co-chairs had written a second letter addressing the response letter they had received from Mitch Katz and Sandra Hernandez. The co-chairs have met with Mitch Katz, at which time Mitch acknowledged the problems with the process used to cut the Planning Support Contract and expressed that he felt sure that the cuts would not cripple the Council's ability to do its work. The co-chairs have also met with the consultants and discussed the specific cuts and how the support will now be provided. Chata stated that they were still not clear how much the DPH/AO staff will pick up, but they have preliminary information that the DPH/AO will be covering supplies, mailings, postage duplication, and messenger costs. Ellen added that the DPH/AO will be providing more concrete information about the cuts, at which time they will address the possible need to restructure the work of the Council.

Jimmie asked for clarification on the specific cuts they are certain of and what impact it would have on the committees. Ellen responded that the specific cuts impacting the committees are as follows:

- Technical Support: Membership and Steering committees will no longer have technical support persons from Harder & Co.. The AO staff will provide support for these committees. The level of support, time-wise, for the Assessment and Linkages Committees will be trimmed.
- Logistic Support: 300 hours cut. This means that the minutes will be faxed instead of mailed to members. The AO will mail Council minutes when there are attachments to be mailed.
- Process Evaluation: Cut 15%; co-chairs evaluation, supplemental task force, exit interviews and other special projects.

The co-chairs have discussed having AO staff replace some of the staff for committee work, however this would not be appropriate for the Process Evaluation support. They also discussed a decrease in the scope of work and perhaps a repositioning on what the priorities are, but again they are still in deliberation.

Ellen outlined the schedule for the Council meetings. The second Thursday of each month will be a full Council meeting lasting 3 hours, from 3 to 6 p.m.. The fourth Thursday of each month will also be a full Council meeting, but it will last only 2 hours, from 3 to 5 p.m., and it will have a more flexible agenda, including; open-mike, group discussions, guest speakers, and qualitative issues. Both meetings for the month of July will be at the First Unitarian Church, on the corner of Geary and Franklin.

3. MEMBER ORIENTATION (EXERCISE)

Ellen introduced this part of the agenda by explaining that they would be participating in a "getting to know you" exercise. The exercise consisted of members separating out into 11 groups of 3 to answer a variety of questions. She urged the members to join groups with people they did not know.

Ellen reconvened the meeting and asked if there were any comments. Joel reported that he had the opportunity to talk with John West who has been working in Paris this last year conducting a research study of gay men there. He added that it would be interesting and beneficial to have him share his experiences with the full Council. John West stated that he would be happy to do that and explained that the study had been of high risk behaviors of men in sex clubs in Paris. He is currently in the process of publishing his findings.

4. NEW MEMBER COMMITTEE ASSIGNMENTS

Ellen introduced the new member committee assignments and reminded everyone that since the committees have been meeting for several months, they should take that into consideration when brining new members up to speed. She explained that the process of assigning the new members included a combination of the new members requests and the principles of parity, inclusion and representation for each of the committees.

Committee Assignments

Assessment	*Linkages*	*Membership*	*Strategic Evaluation*
John Blake West	Marcos Banales	Elizabeth Davis	Mike Discepola
	Sonja Mackenzie	Deja Dior-Britt	Brenda Escobar
	James Rapues		
	Thomas Zickgraf		

5. BREAK

6. COMMITTEE MEETINGS

Members proceeded to their assigned meeting rooms.

Distributed at This Meeting:

- Sexually Transmitted Disease Overview, information and registration form,
- HPPC letter to Katz dated September 13, 1996,
- Response letter to HPPC from Mitch Katz and Gene Copello dated September 26, 1996 (distributed at committee meetings),
- Second National Harm Reduction Conference brochure,
- National Coalition to Save Lives Now! Call to Action, information and endorsement form,
- "Follow Me Home", documentary information flyers,
- "Participant Dialogue" boxes and "Evaluation Results" from the June 12, meeting,
- UCSF AIDS Health Project "Building Hope Benefit Concert" flyers, and
- SF HPPC Standing Committees handout.

Minutes Recorded by: Amalia Fernandez-Niewendorp, Polaris R & D, Inc.
Minutes Approved by: Ellen Goldstein, HPPC Co-chair and Tracey Packer, AIDS Office Staffperson.

HIV PREVENTION PLANNING COUNCIL MEETING

July 10, 1997
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer

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Please read: **Agenda and minutes of June 12 & 19, 1997**
Please bring: **Minutes & Agenda**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Food/Welcome/Introductions/Announcements	Tracey Packer	3:00 - 3:10 PM
2. Minutes from June 12 & 19	Tracey Packer	3:10 - 3:15 PM
3. Public Comment	Chata	3:15 - 3:35 PM
4. "Papers for All" Campaign/Campana "Papeles Para Todos" - Immigration Amnesty Petition Vote	Chata	3:35 - 3:50 PM
5. Supplemental Task Force - Vote Implementation Task Force	Ellen Goldstein and Chata Tracey Packer	3:50 - 4:50PM
6. Break		4:50 - 5:05 PM
7. Unobligated Funds: Young Women's Survey & Detuned Assays (Letter of Concurrence)	Viva Delgado & Dr. Sandy Schwarcz	5:05 - 5:45 PM
8. Process Evaluation Team Report	Kathleen Roe	5:45 - 5:55 PM
9. Closure/Evaluation	Tracey Packer	5:55 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC Meeting - Thursday, July 24, 1997, 3-5 PM, First Unitarian Church 1187 Franklin Street (@ Geary)

HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for July 10, 1997

*** Please note in your calendar any of the following meeting times that apply to you: ***

HPPC:	Thurs., Aug. 14, 3-6 p.m. at the First Unitarian Church
	Thurs., Sept. 11, 3-6 p.m. at the First Unitarian Church
Linkages Committee:	Mon., Aug. 4, 3-5 p.m. at the AIDS Office
	Mon., Aug. 18, 3-5 p.m. at the AIDS Office
Assessment Committee:	Mon., Aug. 11, 4:30-6:30 p.m. at the AIDS Office
Evaluation Committee:	Thurs., Aug. 21, 4-6 p.m. at the AIDS Office
R & R Task Force:	Tue., Aug. 5, 4-5:30 p.m. at the AIDS Office

Members Present:
Barbara Adler
Ronnie (Chata) Ashley
Marcos Banales
Elizabeth Davis
Michael Discepola
Brenda Escobar
Ellen Goldstein
Vic Hernandez
Liz Highleyman
Jelousy Jiggetts
Sonja Mackenzie
Askia Muhammad
Jimmie Naritomi
John Newmeyer
Tracey Packer
Dawn Passar
Bethsaida Ruiz
Steven Sams
John Blake West

Members Absent:
Deja Dior-Britt
Kevin Gogin
Valerie Kegebein
Sacul L'Adnbre
Lisa Moore
Henry Ocampo
J. Colin Partridge
James Rapues
Joel Reyna
María Rinaldi
Sandy Simms
Thomas Zickgraf

Leave of Absence
Jennifer Lorvick

AIDS Office Staff:
Brian Dobrow
Delia Garcia
Mike Pendo

Guests:
Danilo Cuevas, API Wellness Center
Veronica Davila, AO
Valerie Edwards, Westside
Brigette Lachmann (Germany)
Kate Monoco Klein, DPH/Women's Services
Loras Ojeda, Mobilization Against AIDS
Luis Orozco, NTFAP
Heather Rowley, Sunburst Project Volunteer
Esther Thach, AO
Hank Wilson, ACT UP

Harder + Co./Polaris, Inc.:
Amalia Fernandez-Niewendorp, Polaris, Inc.
Lyn Paleo, Harder + Co.

HPPC Process Evaluation Team:
Pali Basi
Ruel Caneda
Raquelle Caras
Kathleen Roe
Kevin Roe

1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Tracey convened the meeting shortly after 3:00 p.m. and asked that members and guests introduce themselves. She welcomed everyone and asked if there were any announcements.

Announcements

Steven Sams

- Distributed a flyer pertaining to the San Francisco Castro Lions Club 10th Annual Leather Auction. To be held July 13, 1997 at the SF Eagle Patio.

Hank Wilson

- Lavender Youth Recreation Information Center (LYRIC) will be hosting a Youth conference on July 13, 1997. There is no need to register - drop-ins are welcome. Admission is free. He encouraged HPPC members to involve their agencies by setting up a table at the conference. The cost for a table is $50.00. It is anticipated that there will be 500 to 600 young people.

- On September 3-4, 1997 there will be a special conference on gay men – MSM, Substance Abuse and HIV. It will be held in Seattle, WA, and is being sponsored by NIDA and CDC. He encouraged interested HPPC members to attend. It would be beneficial to have grass roots

representation to incorporate reality into some of the academic concepts they will be discussing. Information is available to anyone interested in attending. Since space is limited please contact Hank Wilson, ACT UP Golden Gate, as soon as possible at 415-864-0738.

Ellen Goldstein

- NTFAP is conducting a "Plus Two Seminar" July 13-14, 1997. The seminar is for clients who are dealing with HIV who are looking at emotional issues, access issues, information issues, etc.. The "Plus Two Seminar" is an advanced seminar lasting only two days, instead of three. Anyone interested could get specifics from her at the break or after the meeting.

Kathleen Roe

- **All Council members** are asked to fill out the evaluation forms that are distributed at the beginning of every HPPC meeting. Currently the Evaluation Team receives evaluation forms from only ¼ of the Council. This is an imperative part of the process – it allows the Evaluation Team to get a complete and accurate representation of the Council.

Chata Ashley

- Chata informed the Council that he will be taking a leave of absence as of August 1st, 1997 for one month. He wanted to reassure the Linkages committee that he would be participating on that committee upon his return. The co-chairs have discussed his leave of absence and he is confident that things will continue to run smoothly and without any hindrances. He explained that he is no longer at the NTFAP, so any pertinent Council business can be mailed to his home address or faxed to Tracey Packer at the AO. He may also be reached at his home number -- 415-563-5149.

Tracey Packer

- **New Meeting Minutes Protocol**:. As a result of the Planning Support Contract cuts the Council and Committees minutes will now be faxed. Absent members and members without fax numbers will continue to receive the minutes via the US Postal Service.

- **Member Absences**: J. Colin Partridge previously informed the Council (at the June 12th meeting) that he would be absent today. Sandy Simms called to inform the co-chairs that she would not attending today. Maria Rinaldi had a family emergency that took her out of the country. She anticipated returning the 18th of July.

- **Meeting Cancellation**: The August 28, 1997 Council meeting – fourth Thursday of the month -- has been canceled.

- **Participant Dialogue 6/19/97**: In reference to the questions and comments to the Co-Chairs pertaining to the policy on public participation at HPPC meetings Tracey explained that all HPPC meetings – Council, Committees, Task Force, etc. -- are open to all members of the public. Each of these meetings will have its own method of addressing public comments, as decided upon by the members of those meetings. Jimmie added a point of clarification that non-Council members may not participate in the Council discussions, but they may express themselves through public comment. Tracey explained that this information may be found in the HPPC By-laws. Ellen stated that for parity and inclusion, the HPPC meetings are always posted in the B.A.R. notifying the public of the meeting dates, times and location. She also noted that the Council is looking into additional ways of publicizing meetings.

2. APPROVAL OF MINUTES, JUNE 12, and JUNE 19, 1997.
Tracey informed the Council that there was a quorum present to approve the minutes. She asked if there were any comments, revisions or questions for the June 12 or June 19 minutes and there were none. A motion and a second was made to approve both minutes. With a quorum present the minutes of June 12 and June 19 were approved.

3. PUBLIC COMMENT
Chata introduced this agenda item by reviewing the rules for public comment. He explained that all speakers must fill out a registration form. Each speaker has three minutes and will receive a 30-second warning from the co-chairs. Chata introduced speaker *Hank Wilson of ACT UP Golden Gate.*

- Hank began by stating that HIV Testing in Los Angeles is now providing results within 24-hours to their clients. Communities of San Francisco may begin requesting the same service. If Los Angeles is doing it, communities may begin asking why we are not also doing it. He explained that this may be an upcoming challenge SF testing sites will face.

- Hank pointed out that several publishers -- Cuir, Odyssey, Leather Journal and Oblivion[1] – are advertising Poppers in their publications. He expressed his concern that Odyssey and Oblivion target gay youth. He encouraged members to provide these publishers with feedback on how troubling this issue is. He added that publishers need to hear feedback from people and agencies involved in prevention.

- Hank explained that the San Francisco AIDS Foundation distributes a publication called "Behind Our Backs" that includes erroneous information about nitrate inhalants. The information is out of date, factually incorrect, and omits pertinent facts. He informed the Council that he had asked the San Francisco AIDS Foundation to stop distributing this publication to young gay men. He added that he also requested that if they chose not to stop distributing it, they could include an insert/attachment that corrects the erroneous messages. He expressed his belief that it is harder to re-educate people once they have read information from a credible source. He encouraged members whose agencies distribute the "Behind Our Backs" publication to review the contents and revise any erroneous information.

HPPC Response to Public Comment
Steven Sams requested that the inaccurate and amended information from the "Behind Our Backs" publication be made available to him. Hank responded that the information would be made available to anyone interested.

4. IMMIGRATION AMNESTY PETITION - VOTE
Chata introduced this part of the agenda by explaining that Maria Rinaldi had made an announcement at a previous Council meeting pertaining to the "Papers For All" Campaign (Campaña "Papeles Para Todos"). At that time she had requested that the Council support this petition. In her absence Chata asked for feedback from the Council members.

Steven expressed some confusion and hesitation about supporting this petition. It was unclear to him if the petition was requesting amnesty for everyone in the U.S. or if it was requesting amnesty only for

[1]This publication may have stopped advertising Poppers.

those in the U.S. who were documented. He added that the language did not clearly state what the purpose of the petition was. Chata responded that the purpose was to gain amnesty for anyone undocumented – that lives in this country. The intent is to enable them to access services – healthcare, education -- without fear of deportation.

Liz explained that her understanding of the petition, after reading it, was that it was attempting to give everyone permanent residence, which is different than enabling them access to services. She is also unclear if this is a one time opportunity such as the last amnesty which occurred in 1986. Chata responded that as far as he knew it was one time opportunity. Steven was still hesitant to support the petition without some clear and specific information on whether it was to be for accessing services or residency. Jimmie agreed that this petition was unclear. He stated that he had assumed that this petition was in conjunction with Welfare Reform and Federal Legislation that had been passed and which Governor Wilson was proposing to change in the State of California. He added that it needed to be clear whether it is addressing Federal or State amnesty and who it would impact -- individuals who are being exempted from the welfare reform or other individual. If it is amnesty for all -- anyone currently in the U.S. -- the welfare reform stipulates non-U.S. citizens.

Ellen said that because the petition did not have those details and specific language, she had interpreted it as a philosophy statement rather than a legislative proposal. She added that it did state that "currently there are millions of men, women and children in the US who did not qualify for the 1986 immigration amnesty." The petition addresses the problems faced by those particular individuals and proposes a general amnesty. It seems to be in conjunction with the 1986 amnesty and would be for individuals currently in the U.S. She reminded the Council members that they had previously discussed the possibility of writing a letter of support and becoming co-signers of this document.

Elizabeth stated that all individuals should have the right to live where they can feed and support their families as well as have access to healthcare and education. A motion was made to support this petition via a letter of support from the HPPC. The motion was seconded. Tracey facilitated the vote.

In Favor :	7
Opposed:	2
Abstained:	2

Motion passed. A letter of support will be written.

5. SUPPLEMENTAL FUNDING TASK FORCE (SFTF) - VOTE

Ellen distributed a 2 page handout of the SFTF Guiding Principles and their Proposed Priority Interventions for Priority Populations. She gave a brief summary of the SFTF and the tasks which they had completed. She stated that the Council was consulted throughout the development process and that they provided the SFTF with the direction they followed -- through full Council discussions and concept votes. It has been determined by the Council that there would be 3 final funding options: 1) Un-funded lab cost for counseling and testing, 2) Curriculum development for training for PEP and STD integration into HIV programs, and 3) Programs that reach priority populations. The task force also came up with a ranking of the Priority Populations – that was also approved by the HPPC. This information was then written into an application which was sent to the CDC along with a letter of concurrence from the HPPC. The letter of concurrence was conditional in that it stipulated that the AO and the HPPC would continue to collaborate on this project jointly.

The next steps are to determine if the HPPC is in agreement with the Priority Interventions the SFTF developed and the selection of an Implementation Task Force that will determine the mechanisms in which the funding will be released – RFP, augmentation for current grantees, etc.
Ellen referred to the 2 page handout. She read through the Guiding Principles of the SFTF:

1. ***Prioritize interventions within each population category***
2. ***Start at the top and move toward the bottom and get all***
3. ***Fund or ensure programs in each population category***
4. ***Allocate more money for highest priorities***
5. ***Acknowledge that some interventions are linked***
6. ***Acknowledge that some gaps can be filled without additional funding (existing contracts can be modified to expand interventions to reach identified populations.)***

She explained that the SFTF had made a decision to edit down the interventions rather than reduce the number of Priority Populations addressed with this funding. Their intent had been to fund all of the Priority Populations. She asked if there were any questions or comments on the Guiding Principles. There were none so she proceeded to the next section: Proposed Priority Interventions.

Ellen summarized the 8 Priority Populations and their Proposed Priority Interventions. She gave examples of the interventions and then opened the floor for discussion. Chata thanked the SFTF for all of their hard work and their persistence. Through the difficult discussions and sometimes painful disagreements the SFTF stuck with the process. He added that some gaps will always exist, but the Council must stick with the process to eventually see through the eyes of 'Planners' and not just 'Advocates.' The following are questions and comments for each of the Priority Populations and the Proposed Priority Interventions.

First Priority Population: MSM-IDU, MSM/F-IDU, MSM, MSM/F (Male Speed Users)
No specific comments or discussion.

Second Priority Population: MSM, MSM/F (Queer Youth of Color)
No specific comments or discussion.

Third Priority Population: MSM-IDU, MSM/F-IDU, MSF-IDU (Male Injection Drug Users)
Elizabeth asked what was meant by "bisexually acting" (also in the Sixth Priority Population). Ellen responded that they were looking at MSM and MSM/F who may not identify as being gay or bisexual.

Fourth Priority Population: MSM, MSM/F (Native American & African American)
No specific comments or discussion.

Fifth Priority Population: FSM (Risky Partners)
Ellen informed the Council of feedback pertaining to this population from two SFTF members who were not present today. She wanted their voices and opinions represented. The members had expressed their dissatisfaction and frustration that specific programs were not identified for women with risky partners. Ellen further explained that the SFTF discussions led to the conclusion that the SFTF needed to identify the results of the assessment before they could identify appropriate programs. The intent was to be very specific in funding women with risky partners as opposed to funding low risk women. The purpose of the assessment is to determine how best to reach high risk women and how they are currently being reached. Chata pointed out that as an avid advocate for this population he was satisfied to see that

women will be affected by interventions targeted at many of the Priority Populations identified in this slate.

Mike Discepola asked if the Assessment of Service Gaps in 1997 for this population had been initiated. Tracey responded that the AO had begun the assessment and estimated the completion by October of 1997. This will allow 1998 funding to address gaps that are identified. Mike asked for clarification on whether funding from the $719,000 would be set aside for next year (1998) to fund the results of the assessment. Tracey explained that the $719,000 being discussed is for this year - 1997. An additional $719,000 will be available for next year. Ellen added that several of the other priorities, especially those which are put out to bid through an RFP, will not be funded until January 1998 either.

Sixth Priority Population: MSM/F (Closeted Bisexually Acting Males, Particularly Native Americans)
No specific comments or discussion.

Seventh Priority Population: MSM/F, MSF, MSM (Latino, Immigrant, Migrant Indigent)
Jimmie asked if this was the only Priority Population that would address the transgendered population. Chata responded that the transgendered population was included in all of the Priority Populations, but this one has a focus on transgendered populations. Ellen agreed and stated that the Priority Populations would be revised to reflect the transgender population specifically.

Eighth Priority Population: FSM/F-IDU, FSM-IDU (Female Injection Drug Users)
Bethsaida asked for clarification on the decision to use venue-based group outreach (VBGO) for this Priority Population. Askia responded that they had discussed the issue of women who inject not being accessible through traditional individual street outreach; rather women would be more responsive to HIV Education & Prevention messages in some sort of group setting such as needle exchange. The idea of the group setting would also serve to join these women together -- creating a support network for them. Ellen added that they had also looked at the gaps in funding to determine the need to address VBGO. There were multiple session groups (MSG), single session groups (SSG) and venue-based individual outreach (VBIO), but there was not a commensurate level of VBGO. Askia gave the example of the serology testing conducted by the Urban Health Study. Statistics show that many women who participated in the testing every 6 months were women that the outreach workers had not seen at the usual outreach sites, street corners, parks, etc. They were able to reach more of the high risk women at the needle exchange sites and in the group setting.

Bethsaida stated that she was aware of outreach workers going to needle exchange sites but she questioned the reasoning behind VBGO. She was also interested in why an intervention could be chosen for this Priority Population of women and not for the other Priority Population for women, that required an assessment. She asked for clarification as to whether an assessment had been conducted for this Priority Population and if not why not do it in conjunction with the other Priority Population assessment.

Ellen gave a brief summary of the funding amounts for FSM-IDU to help clarify the reasoning behind the decision to use VBGO.

INTERVENTIONS	FUNDING
CTRPN	$159,000.
HOTLINE (a % of the hotline)	$10,000.
IRRC	$114,000.
MEDIA	$11,000.
PCM	$41,000.
NEEDLE EXCHANGE	$112,000.
SSG	$192,000.
MSG	$115,000.
VBGO	$16,000.
VBIO	$251,000.

Ellen pointed out that most of the interventions were in the triple digits. With the above information the SFTF decided to augment the less funded interventions. Initially there were more interventions listed; the SFTF narrowed those down and part of the purpose of today's vote was to determine if the interventions proposed were sufficient. She asked for specific feedback from Council members about interventions and/or other interventions.

Tracey added that the reason the SFTF was able to come up with an intervention for this Priority Population and not the other was that IDUs are more identifiable than women who have risky partners. Women who have sex with men may not necessarily know that they have a risky partner, whereas women that are IDUs do know that they are IDUs and that makes it easier to find them and target them with appropriate programs. With FSM the population is huge (approximately 289,000), therefore attempting to identify how many of them have risky partners and then determine how to specifically target them in ways that are appropriate and effective would be a difficult task. She explained this was the purpose of the SFTF proposal to conduct an assessment for that Priority Population. The intent of the assessment is to determine where these women can be reached, which programs exist, what they are doing, and how they are reaching those women.

Ellen asked if there were any recommendations as to how to improve the intervention for female injectors. Bethsaida stated that she did not agree that the needle exchange was an appropriate site for VBGO. She added that what is required is more PCM and IRRC. She also stated that she is not supportive of VBGO at some of the group settings mentioned; AA, Alanon, etc. It may be feasible in a treatment facility setting, but the funding would be better spent on PCM and ICM. Ellen asked for feedback from other Council members who work directly with this Priority Population.

Dawn gave an example of how VBGO does not work. In a domestic violence group, one of the clients reported no domestic violence or abuse. When the same client participated in a one-to-one session with a prevention case manager she disclosed that she had experienced domestic violence and abuse. Dawn reiterated that PCM needed to be included as an intervention for this population.

Marcos stated that from his experience, he thinks outreach at needle exchange sites is ineffective. He explained that many clients at these sites are under the influence, are interested in getting clean rigs and then quickly leaving. Recently the Forensic AIDS Project had been reaching this population in the hotels

were they live. This -- one-to-one IRRC and PCM -- has proven to be an effective method in reaching this population. He would rather see VBIO, in hotels, than VBGO at needle exchange sites.

Brenda expressed her support for the proposed interventions. Her experience has led her to believe that it all depends on who is doing the interventions rather than what the intervention are. She explained that she has recruited many women -- who were not always sober -- for her groups through AA, Domestic Violence Programs, etc. The approach is what matters to this population. They need to see you repeatedly to develop trust. That is what works with this population, regardless of VBGO or VBIO.

Liz stated that her experience with street-based needle exchange has been very positive. At one specific needle exchange, clients -- who are outside instead of in a formal group setting -- have a responsive attitude. They come and spend time there visiting and accessing PCM and IRRC. These are important interventions that are being done. She explained that this intervention (VBGO) is attempting to reach this population with a new and different method.

Askia asked for clarification on the number of nights and sites that the needle exchanges were currently reaching this women. Bethsaida responded that it was only one night and one site. Askia recommended that they consider the lack of sites and nights available for this intervention. He added that at first he was unsure of how this intervention could work. After many discussions with other members of the SFTF he came to the conclusion that it would work. The SFTF discussed this intervention with the intent to do something creative/new to find and reach this population.

Jimmie expressed his belief that individual - one to one - contacts are more effective at needle exchange sites. He stated that there must be a reason for the limited amount of funding for VBGO in this population. He explained that it could be a result of providers' past experience with this population with VBGO. Perhaps the reason that the charts show less funding for this intervention is that providers felt it was not an appropriate intervention.

Jelousy referred to what Askia said about this intervention being new and creative. Individuals who come to needle exchange come for clean rigs but, they also pick up condoms, pamphlets, and information. This is an opportunity to provide the population with female-specific and culturally specific information. It is a pro-active approach that allows for reaching more individuals.

Ellen pointed out that this VBGO was intended for needle exchange as well as other locations. However, she recommended that they change this intervention to reflect the current conversations and input they had heard from the Council members who work directly with this population. She moved to change this intervention to venue-based IRRC and PCM and then allow the providers to identify what venue-based strategy is more appropriate for their clients. Motion was seconded.

Tracey facilitated the vote to replace the existing intervention --VBGO -- with venue based IRRC and PCM.

In Favor :	11
Opposed:	0
Abstained:	0

Motion passed.

Ellen asked if there was any further discussion on any of the Priority Populations. Sonja recommended that an additional intervention for the Fifth Priority Population – women with risky partners -- could be a media campaign instead of no intervention at all. Ellen stated that a media campaign might not be the most appropriate way to spend funding on this particular population. She explained that since many of these women would not identify as high risk, they would disregard the message. The SFTF did not want to blanket the entire FSM population because of their relatively low risk for HIV. With limited funding it was more effective to narrow the population down by focusing on those women at highest risk. Unfortunately they needed to determine how to narrow the population down, hence the assessment. Tracey added that 13% of the current AO funding is directed to this population -- FSM, FSM/F and FSF. The intent of the assessment is to determine how these existing programs are reaching high risk women so the services may be replicated or strengthened.

Sonja then asked for clarification on whether young women were part of any of these Priority Populations. Ellen explained that there was only one age-specific population – the Second Priority Population: queer youth of color (< 24). All other Priority Populations include individuals of all ages.

John stated that he questioned the SFTF's decision to include media as an intervention in five of the eight Priority Populations. His experience -- 10 years at HAFC -- has been that media has been overly used. He stated that as part of the Evaluation Committee he would be interested to see what information was used by the SFTF to determine the inclusion of media in so many of the Priority Populations interventions. He expressed that he was supportive of this slate, but he was skeptical that media interventions would be effective at this stage of the HIV Epidemic.

Ellen referred to John's comments on the media interventions. She summarized the current media funding for the Priority Populations. She explained that media is the lowest funded of the current interventions.

PRIORITY POPULATIONS	FUNDING
MSM-IDU	$ 80,000
MSM/F	$ 0
MSM	$ 205,000
MSM & MSF	$ 149,000
MSF-IDU	$ 56,000

Steven reiterated the SFTF's intent to incorporate new methods of interventions. The idea was to have media campaigns -- written by and for the specific population -- that could be readily available and accessible to the population. Ellen added that the proposed media for queer youth of color was modeled after the Kegeles/Hays model used in multiple cities. Media includes small and large media. This includes hand cards, bathroom posters, and pamphlets. The SFTF identified a gap in culturally specific and culturally appropriate media for African American and Native American MSM & MSM/F. John agreed that there was a need for language and cultural appropriate media campaigns, specifically for new immigrants.

Askia stated that there are many media campaign materials that are discarded immediately after they are received. However, his own experience has been that people are more receptive to materials that are culturally specific. He recommended that they recruit the advertisers that do media campaigns for television to develop some effective subliminal messages about risk reduction -- how to use safely, etc.

Dawn recommended that the media campaigns be more promotional. Her experience has been that particular populations are more receptive to visual messages; videos, songs, etc.. The key is to have client appropriate messages; clients' language, rap music for youth, etc.

Kathleen pointed the importance of what had been said by several of the Council members at this meeting. She recommended that they revisit the Guiding Principles to incorporate the ideal of culturally specific, new, and innovative methods of interventions.

Askia wanted to clarify that when any committee, Ad hoc, or task force develops information, it is doing it on behalf of the entire Council. If they miss something or are off track, it is up to the Council members to point this out. He expressed his satisfaction with the recent SFTF process and the Council discussions about the SFTF recommendations. In summary he wants the Council to be seen as united and not separate.

Jimmie asked the Council to consider what program, if any, in San Francisco has a Japanese literate, culturally sensitive writer to do any of these media interventions. He explained that they don't exist. He recommended that an assessment be conducted when contemplating language appropriate media. He referred to the seventh Priority Population – Latino, Immigrant, and Migrant Indigents. What was being proposed requires some prioritization. It would cost a lot of money to address all languages and cultures. A motion was made to accept the interventions presented as modified. The motion was seconded. Tracey facilitated the vote.

In Favor :	11
Opposed:	0
Abstained:	0

Motion passed unanimously.

Tracey explained that the work of the SFTF was now completed. She thanked the SFTF for all their work and the Council for their support. The product of the SFTF will now be turned over to the Implementation Task Force (ITF) that will consist of Council members without conflict of interest. The ITF will take the recommendations and develop an implementation plan. The ITF will be discussed and selected at the next Council meeting. Liz stated her concern pertaining to the conflict of interest. It would be more effective to get input from individuals who are already doing the work. She recommended that they consider this when choosing the ITF. Tracey explained that the Priority Populations and Interventions could not be changed by the ITF. The group will have to determine how to get the funding out; through RFP, contract augmentations, etc. The ITF will not have the ability to change the Priority Populations or the proposed interventions, it will be more about the mechanics of getting the money out.

BREAK

6. UNOBLIGATED FUNDS: Young Women's Survey & Detuned Assays

Tracey explained that at the end of every calendar year the CDC sends the AO a Financial Status Report (FSR). This report lists the amount of CDC funding that has not been spent in San Francisco for that year. As a result of salary savings, agencies under-spending, etc., there are years that portions of the funding does not get used. Earlier this year AO staff were informed that the un-spent funds from 1996 were available through a letter of request to the CDC. The letter proposes to utilize the funding for one

time projects that would be capable of spending the money by December 31, 1997. She explained that if the funding is not requested, it goes back to the CDC. She added that Mitch Katz had brought a proposal for using these funds to a co-chairs meeting and explained that although it is often true that unobligated funds are not awarded, they had the ability to request them. (Gene Copello and Chata were at that meeting; Ellen was out of the country). It was determined in that co-chairs meeting that a letter would go to the CDC proposing to fund two HIV prevention projects with the 1996 unobligated funds. The letter sent included a stipulation that if the CDC approved the request, the DPH/AO would request a letter of concurrence from the HPPC. The CDC then responded with letter deferring the request until a letter of concurrence was received from the HPPC.

Tracey referred to the letter dated July 2, 1997 to all HPPC members. The letter described the two projects the DPH/AO had proposed to fund with the unobligated funds from 1996. She explained that the Council would be hearing presentations from representatives of the two projects. After the presentations the Council would discuss and determine whether they support the proposal to fund the two projects with the 1996 unobligated funds.

Chata stated that when Mitch presented this information to the co-chairs, there was a lot of vagueness about whether or not the funding would or could be awarded. He explained that he had been under the impression that the letter they had agreed to send was not a letter proposing specific projects -- but rather a letter to determine whether they could get the funds. He added that the information was presented by Mitch in a three hour co-chairs meeting, in which the first two hours were spent discussing the resignation of Gene Copello and the transition of a new interim co-chair. He summarized that his immediate attention at that meeting had been focused on the resignation and transition of a new co-chair and not on the unobligated funds from 1996.

Liz asked for clarification on the total amount of available funding being discussed. Ellen responded that the total amount of unobligated funds was $556,000. She added that not all of the funds were requested -- the DPH/AO had requested $390,000 for the two projects, leaving a balance of $166,000. Tracey then introduced the first presenter Sandra Schwarcz.

DETUNED ASSAY (DETUNED ELISA)

Presenter Sandra Schwarcz, MD, MPH.

Sandra distributed a one page outline, "A New Model for HIV Prevention: Early infections detection and interventions for clients and their partners". She explained that the Irwin Memorial Blood Center had recently developed a test that uses the blood of HIV infected persons to determine if they have acquired the infection in the past four months. She stated that this technique will open the door to new range of prevention opportunities. Up until now, providers have only been able to inform clients whether or not they are HIV infected. One of the benefits of this new technique -- for HIV prevention – would be the ability of providers to obtain a reliable measure for new infections as well as the risks associated with these new infections. Since most clients at HIV counseling and testing sites participate in a detailed behavioral risk assessment (BRA), providers would be able to compare data from the BRA with the results of the Detuned Assay. She referred to the outline under Evaluation. Using data about clients that had contracted HIV in the last four months, determined by the Detuned Assay, information about HIV Incidence, Population at Greatest Risk, Events Associated with Seroconversion and Transmission Patterns could be generated. Providers could use this information to target their interventions more effectively.

Sandra explained that one of the benefits for clients who had acquired HIV in the last 4 months would be their referral into early medical treatments. One such program is the UCSF Options program. This program offers protease inhibitors which could reduce the disease progression. Another benefit of early treatment is that someone in treatment will theoretically be less likely to transmit the disease. Partners of the HIV positive clients would also benefit in that if recently exposed, they might be eligible to receive medications that may prevent them from getting the HIV infection -- such as Post-Exposure Prophylaxis (PEP). Those exposed to HIV but not infected would be ideal candidates for referral into prevention programs specifically designed to serve HIV negative people. In summary what is being proposed with a portion of the available funding is: a pilot program that would apply the Detuned ELISA to determine when individuals testing positive for HIV have become infected in order to apply public health and prevention strategies to control HIV disease.

Tracey then introduced the second presenter Viva Delgado.

YOUNG WOMEN'S SURVEY (YWS)

Presenter Viva Delgado, Project Coordinator.

Viva explained that the YWS has been in operation since April 1996. She acknowledged her team members present and began with a slide presentation. *(Copies of the slides will be made available to absent members.)* The YWS has been funded by the State of California to conduct a study on HIV & STD's including information on prevalence, risk behaviors, and co-factors. The participants are women 18 - 29 who reside in low income neighborhoods in these five counties: Alameda, Contra Costa, San Francisco, San Mateo and San Joaquin. To date, the San Francisco team has enrolled 366 women -- their sample goal is 500. The total recruited participants to date for the five counties is 1,700 women. The San Francisco team is actively recruiting in the lower income neighborhoods identified by the 1990 Census. These randomly selected neighborhoods fall under the 10% of lowest income. The team goes into these identified neighborhoods to scout, map, and then enumerate the dwellings. Once the enumeration has occurred the team begins their recruitment and enrollment efforts.

Once participants are enrolled, team members conduct a survey/interview, pre-test counseling session, blood draw, urine specimen collection, post-test counseling and prevention education, and referral for health care and prevention services. The purpose of the study is to estimate infection rates of HIV and other sexually transmitted disease -- including STD's and hepatitis B and C. The survey -- that lasts 45 to 60 minutes -- includes questions about participants' behaviors and beliefs pertaining to: sex, drug use, health care, prevention activities, as well as anecdotal information. Participants receive a $40.00 stipend and a $10.00 transportation voucher to get their results. Viva stated that a substantial number of the sample are women of color and the information the staff is disseminating is information of which – alarmingly enough -- many of these women are not aware. The intent of this study is to improve health programs for young women and to develop better methods to prevent disease and promote good health.

Ellen thanked the presenters and asked if the Council members had any questions or comments. Barbara asked for clarification from Sandra regarding the test and the time-frame for results. Sandra responded that the final result could be generated within two weeks. This time-frame will allow for the original ELISA, a confirmatory test and then the Detuned ELISA. She added that the test is uncomplicated and could be done in one week if necessary. Barbara asked how this program's prevention piece fits with seroincidence if there is an anonymity factor – clients are all given a code number to get their results. Sandra responded that when anonymous testers are linked into referrals they often become confidential testers.

Barbara then asked for clarification on the aspect of prevention with partner notification. She was unclear about the plan to address what was now anonymous. Sandra stated that this had been discussed with Jim Dilley -- who was basically very supportive. She added that they had also discussed 'linkage counselors' and the other logistics of the partner notification. Clients that wish to remain anonymous can still divulge the names of partners who can be notified. The final protocol for the implementation of the Detuned Assay will be developed with CTRPN providers to maximize benefits to the client.

Barbara explained that Steven had excused himself earlier but had asked her to share his comments with the Council and the presenters. He was in support of funding the YWS since it could compliment the assessment being discussed in the intervention for the Fifth Priority Population – women with risky partners. Barbara then asked Viva whether the testing being conducted by the YWS was being kept confidential. Viva responded that all of the testing result were confidential and that the lab received only coded tubes. These results are kept confidential and HIV results are always kept separate from the reportable STD results. Only the participant will be informed of the test results.

Vic stated that he was still unsure about spending funds to determine whether or not someone had been infected with HIV in the last four months. He added that since the information Sandra discussed earlier was already being collected – without the time specificity – he was unclear about the need for pinpointing the time-frame of the infection. Sandra responded that when looking at current counseling and testing information providers are not able to determine if the HIV was contracted 5 years ago or last month. The significant value lies in that ability to know when the infection was acquired. It makes all the difference in understanding what is currently happening with HIV. Ellen added that another piece of the proposal was to address incidence data. Vic stated that this was indeed an interesting project, but he failed to see how it tied in with prevention. Ellen summarized that the project tied into prevention in that it would look at new incidence data.

Jimmie asked for clarification on which counseling and testing sites were being considered. His concern was that some sites would not be considered that might result in HIV positive clients. Sandra responded that all of the DPH funded counseling and testing sites were being considered. The only sites missing would be private labs and home collections. Jimmie pointed out that transmission routes could only be ascertained through self disclosure, therefore the results could not be absolute. In that the test would have a margin of error and not everyone develops detectable anti-bodies at the same rate, how would the results be differentiated. Sandra responded that all tests -- standard ELISA, Syphilis, new ELISA, etc. -- will have a margin of error. However the information available for this new ELISA test is quite compelling.

Liz expressed her support of the projects and explained that through the entire epidemiological process everyone had asked for new incidence data. John West stated that both proposals were outstanding. He expressed some concern about the YWS, and the perception of CDC that the project would occur anyway without this funding. He explained that skepticism is high when it appears that a grantee is using funds that would otherwise be made available by the department. He added that he is not downgrading the project but rather giving a heads up about what might not be awarded. Viva explained that without this funding they will not be able to complete their sample.

Barbara asked if the Detuned ELISA could also be done orally. Sandra responded that as far as she knew it was only available for blood testing.
Tracey noted that time was running out and that the Council members had the following options: a) Vote on a letter of concurrence for the two projects today, b) Postpone the vote on a letter of concurrence until

the next meeting when the Council could further discuss requesting the balance of the unobligated funds, and c) Vote on the letter of concurrence for the two projects today and then discuss requesting the balance of the unobligated funds at the next meeting, providing this would not interfere with accessing the unobligated funds.

A brief discussion was conducted in which the Council members discussed the possibility of checking with the CDC to determine if they could request the funds in two separate letters. The Council agreed to only write the letter of concurrence for the two projects – Detuned Assays and YWS – if they could request the balance in a second letter. Otherwise, they would hold off on this letter until further discussion on the balance of the funds at the July 24th Council meeting. Vic requested that the Council members be notified of the CDC response. Ellen then conducted several straw votes to determine what the Council members wanted. A brief discussion occurred pertaining to the possibilities of: 1) jeopardizing the two projects by waiting, and 2) the loss of opportunity to apply for the balance of the unobligated funds by waiting.

A motion was made to vote for the letter of concurrence for the two projects and then discuss requesting the balance of the unobligated funds at the next meeting on July 24, 1997. The motion was seconded. Tracey facilitated the vote.

In Favor :	9
Opposed:	1
Abstained:	0

Motion passed. A letter of concurrence will be written for the two projects with a stipulation that the HPPC requires additional time for requesting the balance of the unobligated funds.

Distributed at This Meeting:

- San Francisco Castro Lions Club, 10th Annual Leather Auction flyers,
- Westside Community Mental Health Center, Job Announcements: 1) AIDS Case Management Program, and 2) Outpatient Services and HIV Women's Prevention Project,
- "Participant Dialogue" boxes from the June 19, meeting,
- Supplemental Funding Task Force, July 1, 1997 "Guiding Principles" and "Proposed Priority Interventions for Behavioral Risk Populations.",
- "A New Model for HIV Prevention: Early infections detection, and interventions for clients and their partners.",
- "It's a She Thang: A Young Woman's Guide to HIV and STD's"

Minutes Recorded by: Amalia Fernandez-Niewendorp, Polaris R & D, Inc.
Minutes Approved by: Tracey Packer, AO Staffperson and Ellen Goldstein, Co-chair

REVISED AGENDA

HIV PREVENTION PLANNING COUNCIL MEETING

July 24, 1997
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer

Please read: **Agenda**
***Please bring*: Agenda**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Food/Welcome/Introductions/Announcements	Chata	3:00 - 3:10 PM
2. Establish Implementation Task Force	Tracey Packer	3:10 - 3:15 PM
3. Unobligated Funds (continuation of discussion from 7/10/97)	Ellen Goldstein	3:15 - 4:00 PM
4. Summary and Preliminary Results from 1997 HIV Prevalence Consensus Meeting	John Newmeyer Kimberly Shafer	4:00 - 4:40 PM
5. Break		4:40 - 4:55 PM
6. The Delta Project - An Update	Valerie Kegebein	4:55 - 5:35 PM
7. Public Comment		5:35 - 5:55 PM
8. Closure/Evaluation	Chata	5:55 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC Meeting - Thursday, August 14, 1997, 3-6 PM, First Unitarian Church 1187 Franklin Street (@ Geary)

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HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for July 24, 1997

* Please note in your calendar any of the following meeting times that apply to you: *

HPPC:	Thurs., Aug. 14, 3-6 p.m. at the First Unitarian Church
	Thurs., Sept. 11, 3-6 p.m. at the First Unitarian Church
Linkages Committee:	Mon., Aug. 4, 3-5 p.m. at the AIDS Office
	Mon., Aug. 18, 3-5 p.m. at the AIDS Office
Assessment Committee:	Mon., Aug. 11, 4:30-6:30 p.m. at the AIDS Office
Evaluation Committee:	Thurs., Aug. 21, 4-6 p.m. at the AIDS Office
R & R Task Force:	Tue., Aug. 5, 4-5:30 p.m. at the AIDS Office

Members Present:	Members Absent:	Guests:
Marcos Banales	Barbara Adler	Marshia Herring, AO
Elizabeth Davis	Ronnie (Chata) Ashley	Patrick Horton, AO
Michael Discepola	Deja Dior-Britt	Kim Shafer, AO HIV Prvnt. Indicator Project
Brenda Escobar	Kevin Gogin	Irene Carmona, AO - Delta Project
Ellen Goldstein	Jelousy Jiggetts	
Vic Hernandez	Lisa Moore	Leave of Absence
Liz Highleyman	J. Colin Partridge	Jennifer Lorvick
Valerie Kegebein	James Rapues	
Sacul L'Adnbre	Joel Reyna	Harder + Co./Polaris, Inc.:
Sonja Mackenzie	Sandy Simms	Amalia Fernandez-Niewendorp, Polaris, Inc.
Askia Muhammad	Thomas Zickgraf	Lyn Paleo, Harder + Co.
Jimmie Naritomi	John Blake West	
John Newmeyer		HPPC Process Evaluation Team:
Henry Ocampo	AIDS Office Staff:	Pali Basi
Tracey Packer	Brian Dobrow	Raquelle Caras
Dawn Passar	Delia Garcia	Kathleen Roe
María Rinaldi	Mike Pendo	Kevin Roe
Bethsaida Ruiz		
Steven Sams		

1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Ellen convened the meeting shortly after 3:00 p.m. and asked that members and guests introduce themselves. She welcomed everyone and asked if there were any announcements.

Announcements

Steven Sams

- Distributed a flyer pertaining to the San Francisco Castro Lions Club. The JUMA Ventures & Castro Street Ben & Jerry's Ice Cream Store celebrates one year in business. The celebration is scheduled for August 10th, from noon until 4 p.m. Proceeds of the day will benefit the Castro Lions Charities.

- Distributed a second flyer pertaining to the San Francisco Castro Lions Club Third Annual "Till There's A Cure Fund-Raiser." Tickets are now available to the Giants vs. the Anaheim Angels game day; Sunday August 31st, at 1:05 p.m. All seats are lower reserved on the first base side of the field. The cost is $15.00 per ticket. They are available today from him or they may be ordered through either Michelle Jester at 510-901-6308 or at 584 Castro Street. BOX 200, San Francisco, CA 94114.

Ellen Goldstein

- "Community Planning, Leadership Orientation and Training" conference to be held in October of 1997. Sponsored by National Minority AIDS Coalition (NMAC) in Portland, Maine. The conference targets outreach, training and advocacy for people of color who are interested in working with Community Planning and HIV Prevention.

- "Fighting Back: African American and Latino Prisoners Struggling to Survive HIV Infection." Presented by Laura Fishman of the Sociology Department at the University of Vermont on August 21, 1997. No Fee.

- "HIV Prevention Strategies for Hard to Reach Populations." Free workshops in Ventura, Los Gatos, and Sacramento throughout the fall. Sponsored by the Center for Behavioral Research.

- **Member Absences:** Chata could not be here due to a medical emergency. J. Colin Partridge previously informed the Council (at the June 12th meeting) that he would be absent today. John Blake West called to inform the co-chairs he would not be attending today. Barbara Adler is in Atlanta, GA for the Gay, Lesbian, Bisexual, and Transgender HIV AIDS Conference. She will debrief the Council upon her return.

2. ESTABLISH IMPLEMENTATION TASK FORCE

Tracey explained that in the past months there had been some discussion about an Implementation Task Force (ITF). This ITF was discussed as a way to follow through with the Supplemental Funding Task Force (SFTF) work – prioritizing populations and interventions, which has been completed. It had been determined that the ITF would consist of AO staff and Council members without conflict of interest. The ITF would have determined recommendations as to how the supplemental funding could be allocated -- augment existing contracts and through an RFP as necessary. It became evident that the Council had never had a precedence for an ITF and that it was an idea that had never come to the Council as a concept for discussion and approval. Therefore the DPH/AO decided to use a process that was accepted, approved, and used by the Council in the past. Tracey added that the Roles and Responsibilities Task Force (RRTF) had been considering the inclusion of an ITF in their document, but had recently determined that it would not be included. (More information on the RRTF will be available at the next meeting.) One of the issues surrounding an ITF is the issue of conflict of interest. She stated that the criteria used by the DPH/AO for conflict of interest is that an individual has served as a staff person and/or a board member in the past 2 years to an agency that could apply for funding. This could eliminate a lot of Council members. Since there was a possibility that there would be few representatives from the Council, it was determined that process was inappropriate.

Tracey stated that the DPH/AO proposes to develop criteria that will be used by the AO to determine what current AO contracts could be augmented to meet the needs that were identified by the SFTF. These criteria could include: which agencies are interested in providing said services, whether the agency is capable of providing these services, and other criteria. Along with that, the AO would develop criteria that would determine whether it's necessary to have an RFP or if all of the SFTF priorities and interventions could be implemented through contract augmentations. Once the AO develops this draft, it will be forwarded to the Council members for review and feedback. The AO will then attempt to incorporate any of the feedback and additional criteria. On August 14th, the AO will present the revised draft of the criteria to the Council with information about what feedback was given, what feedback was incorporated or not incorporated, and the reasons why. In summary, this will be the method used by the AO to implement the

recommendations from the SFTF. Valerie added the RRTF – which was responsible for this new process -- is comprised of Council members, co-chairs and AO staff.

Elizabeth asked for clarification on the process proposed. Tracey explained that instead of an ITF, the AO Prevention Unit -- Mike Pendo, Delia Garcia, Tracey Packer, Brian Dobrow, Valerie Kegebein -- will develop a draft of criteria for the implementation of the SFTF recommendations. This draft will be approved by the Director of the AO, Mitch Katz and then the draft will be sent to the entire Council with sufficient time for members to respond. The following table depicts the three (3) sets of criteria discussed so far: 1) Determine which agencies (current contracts) can provide the interventions, 2) Determine what would call for an RFP instead of augmenting current contracts, and 3) The specifics/requirements for the RFP.

CRITERION ONE EXAMPLES	CRITERION TWO EXAMPLES	CRITERION THREE EXAMPLES
Cultural competency. Experience w/ client population. Experience w/ the interventions.	No agency interested in providing services. No agency capable. No agency has the experience. (note: this may occur with one or more of the priority populations.)	Describe their population. Describe how input from the population is utilized in program development. (information in most RFP's.)

Tracey explained that once feedback was received from the Council, the AO staff would integrate the feedback into the criteria to the extent that they could. She clarified that there might be some feedback that could not be integrated due to legal or regulatory reasons. This revised draft would then be sent to the Council and would be placed on the agenda of the August 14th Council meeting for full discussion. The AO would identify to the Council which feedback given by the Council members was used or not. Tracey added that it would be suggested that agencies meeting the criteria for augmentation would submit a two page proposal stating their capability and the methods they would use to implement the interventions with the amount of funding available.

Elizabeth asked if it was possible to have funding left over for RFPs. Tracey stated that it was possible since they had both 1997 and 1998 funding available. She added that all 1997 funding must be encumbered (committed to a certified contract) by December 31, 1997. Since the 1998 funding does not have to be encumbered by December 31, 1997, that funding would be available for the RFPs.

Steven asked for clarification as to why the original concept was discarded. Ellen explained that due to conflict of interest issue, the Council would not have been fully represented in the ITF. The ITF would be relying on partial information from Council members who were not working with the populations.

3. UNOBLIGATED FUNDS (Continuation of discussion from 7/10/97)
Ellen introduced this section of the agenda. She explained that this funding was different from the supplemental funding previously discussed. The unobligated funds were identified in the AO year end Financial Statement Record (FSR). As a result of agencies' under-spending by the AO, salary savings, etc., portions of the 1996 funding were not spent. If these unspent funds are not requested, they return to the CDC. At the last Council meeting it was determined, via a Council vote, that a letter of concurrence would be sent to the CDC proposing to utilize a portion of the funding for two specific projects, the Detuned Assays and the Young Women's Survey. In addition to that request, there is an additional $166,000 of unspent funds that may be requested. Unlike the supplemental funds and other funds that have been applied for, these funds are more uncertain. The CDC usually does not grant this unspent money, but

there is a strong indication that it may do so on this occasion. The two specifications that have been stipulated are: 1) the funding must be spent on a one time project and 2) the funding must be spent by December 31, 1997. The DPH staff looked at HPPC prioritized research projects to determine if they could complement them with these funds. Unfortunately none of those projects could be implemented and completed by December 31, 1997.

Ellen stated that the Council must now determine whether to apply for the balance of the unobligated funds of $166,000 – and if so what projects or ideas could be funded with the money. The CDC has given a deadline of July 31, 1997 for a letter of concurrence.

Jimmie asked whether the letter of concurrence had been sent and the amount of funding requested for the two projects. Ellen responded that it had been sent requesting approximately $390,00.00. Jimmie then asked if there were any recommendations – short term programs on the drawing board or any existing programs that were almost done that could utilize the money. He added that at this point he is reluctant to make any suggestions since he is unaware of any such programs. Ellen responded that the floor is open for ideas. She stated that some the possibilities discussed were: underwriting a series of town hall meetings to discuss a variety of issues, such as HIV infected women, street outreach, HIV infection in correctional facilities, etc. These would be one time costs that could be completed by December 31, and they would be supporting the goals of community planning.

Jimmie asked for clarification on whether the funding could be used for the community planning process. Ellen responded that it could. Jimmie then stated that it might then be applied toward the recent cuts to the planning support contract. Ellen agreed that it could, however, through the letters the Council had sent and the many discussions with the DPH/AO, the co-chairs were able to negotiate the restoration of $25,000 to that contract. She expressed her belief that that contract is sufficiently funded.

Marcos recommended two possibilities. One was to begin the funding for the African American Gay and Bisexual Study, the highest priority study in the Plan. The other was the Hermanos de Luna y Sol, a Latino Gay and Bisexual Men's Study already in progress.

Vic stated that regardless of how the money is distributed, it should be done in an equitable manner. He referred to the idea of a town meeting and recommended that they begin more broadly by inviting the community and asking them for input as to where they felt prevention funding needed to be targeted.

Sonja expressed her discomfort at this new process. She had just experienced the process of identifying the Priority Populations and Interventions for the Supplemental Funding and this 'Free Money' concept was hard to accept. Valerie stated that this new process should intermingle with the priorities set by this Council, including the supplemental funding. She suggested the possibility of paying for some of the media interventions from the supplemental funding with this money, therefore allowing more of those funds to be spent on the other identified interventions. Steven and Dawn both agreed and supported this last recommendation.

Elizabeth recommended a peer education training project where youth could receive peer education training with certification (to add to their resumes) and possibly a stipend.

Bethsaida asked if the supplemental funding option – assessment of women with risky partners – was already funded. Tracey explained that it was currently funded through staff at the AO.

Henry referred to BAPAC which had given a presentation to the Council several months ago. Since their research funding had been cut, they requested information on available funds and support. Kevin mentioned that BAPAC might be receiving funding through CARE. Ellen agreed but recalled that even with that funding they needed more money.

Jimmie recommended that they comb through the application of the supplemental funding to determine if any of those interventions could be addressed with these funds. It may be that the $719,000 supplemental funds will not cover all of the proposed interventions. One possibility could be to augment the lab cost.

Valerie added that they had previously thought they would be getting an additional $70,000 to $90,000 to complement the $719,000. The DPH/AO had planned to use that funding on the Post-Exposure Prophylaxis (PEP) media campaigns. Unfortunately, the DPH/AO will not get that funding, therefore she recommended the possibility of adding the PEP media campaign to the list of suggestions.

Dawn added another possible media campaign which she had seen utilized in New York. She stated that the public telephones had an HIV information and referral sticker on the receiver. This strategy seemed to make the prevention message available and accessible. Ellen agreed that this might be a possible campaign idea that could address the supplemental funding interventions.

Ellen summarized the list of suggestions for the $166,000.

- African American gay and bisexual men's study
- Latino gay and bisexual men's study
- Town Hall Meetings
- Media which would fit in line with the proposed interventions for the supplemental funding
- Media for PEP
- Peer Education Training
- BAPAC (Funds for perinatal AIDS prevention)
- Lab Costs which fit in line with the proposed interventions for the supplemental funding
- Proposed interventions for the supplemental funding that meet the unobligated funds criteria. (One-time costs expended by 12/31/97.)

She recommended that at this point they needed to prioritize what they had come up with. She asked the AO staff to give input on any of suggestions which may not be feasible funding possibilities.

Valerie responded that the only one that seemed to stand out as not being feasible was funding for perinatal services, due to the time constraint, as well as the fact that it would not be seen as a one time project. Steven recommended that the Council first determine if they should look to fund the supplemental funding interventions that fit under the unobligated funds criteria and then prioritize the other suggestions.

Ellen asked for a straw vote of all those in favor of that recommendation. The Council was in support of this option.

Michael expressed his lack of support and hesitation with the proposed PEP media campaign. He was not supportive of funding research driven media campaigns. Vic stated that he was interested in seeing how much funding was being discussed for the PEP and other media campaigns. Valerie responded to both comments. She explained that the PEP media campaign discussed was not for or against PEP, but rather an informative and educational piece about PEP. The intent was to reinforce prevention efforts while

informing the public of the pros and cons of PEP. She explained that initially $50,000 had been budgeted for that campaign. This was an estimate and it may cost less, since posters and placards would be used, which tend to be less expensive. Overall, all the media campaigns combined could range from $10,000 to $50,000 for the smaller campaigns and as much as $100,000 for the largest campaigns. Michael expressed his support of the PEP media campaign if its purpose was to educate the public.

Steven made a motion to set aside one time costs up to $100,000 to offset supplemental funding priorities set by the Council with the balance of funds to be spent on something that was yet to be prioritized. There was a second. Ellen facilitated the vote.

In Favor :	9
Opposed:	0
Abstained:	1

Motion passed. Ellen asked for input about prioritizing for the balance of $66,000. Sonja stated that since it was not clear that they could get the funding for research studies, she would opt for the peer education training since it was not currently being done.

Jimmie explained that he had abstained from the vote because he was not in favor of locking into something without all of the facts – specifically how much it would cost and what the process would be. Without any indication of what could or could not be completed in the time frame he was hesitant.

Ellen responded that this process was similar to when the Council first prioritized the PEP, Lab Cost and Program Costs. Once they had determined the priorities, they were submitted to the AO, which then provided calculated figures about the costs in the application. She added that the Council needed to agree upon some broad priorities to submit to the AO so they could get a letter out as soon as possible. She added that the Council did have the option of not applying for the funds if they could not reach any conclusion today.

Vic stated that he was in agreement with Jimmie. It was difficult to commit to something so vague. He added that to fund a one time project such as the peer education program seemed futile, since it was simply placing bandage funding on a much larger problem. He expressed his concern that the project would be initiated and then disappear leaving the youth hanging. He is not in favor of setting youth up for something like that. Bethsaida also expressed her lack of support for the peer education suggestion. She stated that it did not seem to be a cost effective option.

Tracey pointed out that in looking at the supplemental funding the AO determined which funds could be spent in 1997 that would not be a cost replicated in 1998. In doing that, they had identified some of the interventions that could be completed this year. An example was the media campaign for Priority Population #1 (speed users). The funding could be spent on the campaign this year in the development of the materials, conducting focus groups, one to one interviews, etc. This could be done by December 1997. This would be a one-time cost. She added that the benefit of using the unobligated funds to pay for some of the supplemental funding interventions was that they could use more of the supplemental funding for the other proposed interventions.

Jimmie clarified that the Council had already agreed to use $100,000 of the unobligated funds on the appropriate supplemental funding interventions. The question they must now address is what to do with the balance of $66,000. He referred to the list of suggestions – excluding the supplemental funding interventions – and which of those suggestions could utilize the $66,000.

Valerie explained that the Council members did not have to decide today which of the suggestions they wanted to fund with the $66,000. They could send a letter, no later than July 31st, to the CDC stating that they wanted to use the balance of the unobligated funds for one time costs, up to $100,000, in the supplemental funding priorities set by the Council, with the balance of the funds $66,000 to be spent on the list of suggestions under discussion.

Bethsaida made a motion to send a letter of concurrence requesting the balance of the unobligated funds for one time costs, up to $100,000, identified in the supplemental funding priorities set by the Council with the balance of the funds ($66,000), to be spent on the list of suggestions under discussion:

- African American gay and bisexual men's study
- Latino gay and bisexual men's study
- Town Hall Meetings
- Peer Education Program
- Funding for Perinatal AIDS Services in San Francisco

Sacul seconded the motion. Ellen facilitated the vote.

In Favor :	9
Opposed:	0
Abstained:	1

Motion passed.

4. SUMMARY/PRELIMINARY RESULTS: 97' HIV PREVALENCE CONSENSUS MEETING
Presenters Kimberly Paige Shafer, AO HIV Prevention Indicator Project and John Newmeyer, HPPC Member and at Haight Ashbury Free Clinics, Inc. Kim began with a slide presentation. *(Copies of the slides will be made available to all members.)* She explained that the AO had hosted a second HIV Consensus meeting that occurred on May 12, 1997. (The first was in 1991.) The meeting was attended by researchers, public health officials, and other experts in the field. The purpose of the meeting was to produce plausible, credible estimates of HIV prevalence and incidence in San Francisco. The process of the meeting was not a compilation of population-based estimates, but rather a panel of experts guided by available data and educated guesses when data were not available. The objectives were to agree upon plausible and credible estimates; risk population size, HIV prevalence, HIV incidence, etc., for San Francisco in 1997.

For clarity Ellen asked for a brief summary of the technical terms being used. Kim explained that HIV prevalence is very important measure that slices through the population and results in a description of how much infection there is at the given time. It is not about how many AIDS case there are – although they are connected – and it is not about how many new cases there are. It is how many cases of HIV there are today or this year. HIV incidence is an estimate of how many -- or the rate -- of new infections in a given month or year. For the consensus meeting they looked at the rate in one year.

Kim referred to the next slide which addressed some of the background for HIV estimates in San Francisco. She explained that the slide depicted the prevalence of people living with AIDS for March 1997. The transmission categories were identified using the same language used by the HPPC Plan. The total number of known persons living with AIDS diagnosis in San Francisco for March 1997 was approximately 6400.

This undoubtedly represents a proportion of the total of HIV infection. When this total proportion is broken down by gender, the total number of known men living with AIDS diagnosis is approximately 5500. The total number of known women living with AIDS diagnosis is approximately 450. There is a greater proportion of HIV prevalence. In response to a question from a Council member, Kim explained that the category "no identified risk" pertained to individuals who reported no risk behavior – people who were never an IDU or participated in any sexual risk behaviors.

Sacul asked for clarification on the numbers identified on the slide. Kim explained that in San Francisco there were fewer than 7,000 AIDS cases known to be alive. Since AIDS is a reportable disease these numbers have been identified using the latest reported data.

Kim referred to the next slide that gave the prevalence of infections collected by nine San Francisco clinics on HIV positive clients. During the months of July - December 1995 there were approximately 8,800 infections. This again is a proportion of the population of HIV infection, however it gives us an idea of who is infected. Sacul asked if these numbers were taking into consideration the numbers of people who are not testing at the clinics. Kim responded that these estimates are not necessarily representative of the entire population, but rather representative of those individuals who utilize the clinics. The intent is to put together the pieces using all of the different views.

Kim stated that the next slide looked at HIV seroincidence – new infections -- among repeat testers. She explained that the method used to determine these new infections was to look at the number of individuals infected among repeat testers at the counseling and testing centers. There were 1.6 new infections per 100 person years for MSM (non-IDU) in this group. John added that although heterosexual men in this group are high risk because of their selection of this population (repeat testers), the real rate of seroconversion among heterosexuals is probably less than .17 out of 100 person years.

Kim explained that the participants of the meeting weighed the limitations of the data and then voted on a central estimate and range. They agreed that the information would not be published without permission and that the final report – written by AO – was subject to iterative reviews by the participants of the meeting. Some of the reasons the Consensus meeting was undertaken were: the HIV Prevention Indicators Projects, planning for the HPPC, planning for prevention and health services, and as a reference for grants and applications, etc.

Kim explained that the 1996 HRSA HIV Estimates depicted approximately 16,000 persons living with AIDS -- for the three counties of San Francisco, San Mateo, and Marin. The 1991 HIV Consensus Figures depicted that San Francisco alone had approximately 28,000 persons living with AIDS. This discrepancy was a red flag that would be discussed later in the presentation.

The 1996 Holmberg HIV Estimates showed approximately 26,000 infections – persons living with AIDS -- for the three counties of San Francisco, San Mateo, and Marin. In response to a Council member's question, Kim explained that this data was gathered and modeled in many different ways. Most was gathered from available AIDS data and then incorporated into a mathematical model. She added that it was based on certain assumptions and references that existed and helped to calculate the results. She pointed out that the Holmberg estimates were significantly more than the HRSA estimates that were compiled at the same time. Vic stated that this discrepancy could be a result of the changing definitions of AIDS and HIV and that these issues were two separate things. Kim agreed and reiterated that they were discussing two separate issues, AIDS as opposed to HIV. She explained that in 1997 there were approximately 7,000 persons in San Francisco living with AIDS and that the 1991 estimates of HIV infections were the same as the 1996 estimates, based on the sero-positivity for HIV.

Kim referred to the next slide that showed AIDS Reported Cases from 7/81 to 3/97 and a graph of San Francisco AIDS Incidence, Mortality, and Prevalence. She pointed out that in 92-93 there was a peak in the number of AIDS cases in San Francisco that then began to decline rapidly. The deaths due to AIDS peaked in 94-95 and then that too began to decline. She stated that what this graph also shows is a huge increase in the number of people who are living with AIDS, therefore we can assume that HIV infection has to be greater than what the graph shows.

She went on to the next slide which showed the result of the '91 Consensus meeting. She explained that these were the background materials used for the May '97 meeting which followed the same format as the '91 meeting. In '91 the results suggested there were almost 28,000 HIV positive individuals, of which 25,000 were MSM. The HIV prevalence for IDU's -- both men and women -- was 1,700. The 91' results also estimated that in the following year there would be 1,850 new cases of HIV infection -- incidence estimate. It was also estimated that 4% of the total population in San Francisco was HIV infected and that .15% would become infected.

Jimmie asked if the '91 estimates were based on the previously mentioned counties – San Francisco, San Mateo and Marin. Kim explained that the results for the '91 estimated were based solely on San Francisco City and County.

She referred to the '97 results that determined that currently there were 15,000 HIV infections in San Francisco and that 500 new HIV infections were estimated to occur this year. John explained that the meeting participants had agreed to discount the earlier numbers and use the more up-to-date science and information. Kim pointed out that the estimated number of MSM had changed -- from 58,000 to 43,100 -- based on a recent study of gay and bisexual men in San Francisco. She added the following: Of the current HIV infection -- 87.5% is among MSM, 8.7% is among IDU's (both men and women), and 3.3% in other heterosexual populations. Ellen added that this information could also be found as attachments in the recent application sent to the CDC for the Supplemental Funding (referred to the blue copies of the application sent to all Council members).

Kim went on to explain that the 1997 Consensus meeting had estimated that 67.2% of the new HIV infections would occur among MSM, 23.4% would occur among IDU's (both men and women), and 9.2% in other heterosexual populations. She stated that these were all guesses with the exception of the MSM, because of the access to true incidence data for that risk group. She pointed out that the '91 estimates that predicted 22% of new infections to be among IDU's had not been actualized.

John explained the incidence column of the '97 results indicated was the front-line of HIV seroconversions. He explained that the Council would benefit the most from this particular information. He gave the example of women in these estimates. It is estimated that 14% of new HIV infections will be in women. At the rate in which women are seroconverting, the 5% HIV prevalence of women is not as important in terms of prevention focus as new infections. Kim added that it was important to note that although that number is a high proportion of the new infections, as an absolute number it is much lower than previous years. The 1991 data estimated 185 new infections among women; the 1997 data estimates 70 new infections among women of all risk groups combined. While the proportion is higher, the absolute number is lower and that is a result of the reduction of new cases among MSM. Maria asked if this was an indication of the effectiveness of the prevention efforts – the reduction in new HIV infections. John explained that it may be seen as such with IDU's, but not necessarily with women. Kim gave the example of a pie that had gotten smaller. Since the population size of the pie decreased for MSM and not for women, women now have a higher percentage of that pie, but not higher numbers of infections.

Jimmie stated that several years ago the bottom line was that there would be 1,000 new infections per year, the new estimates show only half of that. The information presented earlier also shows greater number of people living with AIDS. With this information we can assume that CARE funding should be elevated. If this is the case, then we must look at the possible ramifications of this information to prevention resources. He expressed his concern at being able to justify the prevention budget. John responded that this information should not negatively affect prevention. He added that even if 1/3 of the 500 people were to die from HIV infection, it would be larger than the number of deaths due to homicides and suicides in that given year. This is a much bigger problem than homicide and suicides put together. He also pointed out that it is disgraceful that older gay men, a populations which has received intensive prevention efforts, still have the same rate of new infections as IDU's, therefore requiring more prevention efforts all around.

Steven asked where the population size estimates came from. John explained that he had provided the IDU information. The rest of the information had been derived out of separate studies including the gay Urban men's study. Kim added that these estimates were also based on census data and other informative data that had been collected an validated in several ways. She added that this information is a point estimate that is capable of swelling and shrinking as populations often do. John stated that it is no longer a belief that half of the gay men in San Francisco are infected, since estimates show the percentage at 30% instead of 50%.

Liz recommended that although the reduction in the numbers could be an indication that prevention efforts are working, it may also be an indication that previous estimates where too high. Vic asked whether their methodology was able to utilize any information about migration and if not, how did they account for that. Kim responded that there was data available on migration patterns that was taken into account. She reiterated that these are point estimates that reflect what happened in May '97 and not necessarily what will happen next year.

Sacul expressed her concern that these estimates did not accurately represent the number of new infections for women. She added that many women are either in denial or unaware of their HIV risk so it would be difficult to include them in these estimates. Kim responded that they had several reputable research studies done on women from many sources. She referred to one researcher who had commented on the difficulty of locating HIV positive women. The most recent seroprevalence door to door study being done by AO -- the Young Women's Survey (YWS) which tests women for HIV -- is also finding low rates of HIV infection among women. Sacul stated that unless these women tested, they would not know they were HIV positive. Kim agreed yet stated that the estimates are based on a lot of other data besides counseling and testing and STD clinics. They approached this risk group with both population based studies and high risk studies. She reiterated that this is an estimate of people that will become infected. The current estimate of women already infected is 750. John added that nine years ago he had made an alarmist prediction about the number of female infections. He said he had been wrong (the infection rate did not go so high). He felt the reason he was mistaken was that there were fewer HIV positive straight men to infect the women than he suspected.

John referred to the next slide that depicted the distribution of AIDS/HIV infection by race/ethnicity. He pointed out his predictions for new HIV infections for the coming year: White - 55%, African American - 25%, Latino - 15%, Asian /PI - 4%, Other - 2 to 3%. He explained that he based these predictions on the analysis of the information available on the separate risk groups. He explained that his prediction for the African Americans was higher than the other percentages -- 1996 AIDS, 1995 STD Clinics and 1991 through 95 Youth Centers -- because he was taking into consideration the fact that infection rates among gay African American men were much higher than that of gay White or Latino men, particularly among

African American IDU's. He projected that 25% of the new infections will be among African Americans. In summary he recommended that people take this into consideration when developing the outreach, prevention, and media efforts.

Ellen thanked the presenters. She stated that this was a lot of information to absorb in the allotted time. She extended an invitation to the presenters to return for an additional discussion on this issue.

BREAK

6. DELTA PROJECT UPDATE

Tracey reconvened the meeting. She explained that the Delta Project had been proposed by the 1994-95 HPPC. A task force -- similar to the SFTF -- was formed to discuss recommendations for CDC supplemental funding. The study proposed looking at Females who have Sex with Males who have Sex with Males (FS/MSM), to determine 1) Specific population information -- behavior risks, demographics, etc., 2) Feasibility of accessing the population, and 3) the needs of the population – HIV positive, negative or status unknown. She then introduced Valerie Kegebein and Irene Carmona.

Valerie noted that this is the 3rd update on the study to the Council. She indicated she presented some of the results at the American Public Health Association Conference last November. She gave the history as follows: 1) This population had been identified as a priority for supplemental funding in late 1994 by the HPPC. 2) Little information existed for this population. 3) Originally the goal was to explore needs among women whose partners were both IDU and MSM. 4) The AO had provided funding via an alternative solicitation (like an RFP), for agencies serving female partners of IDUs, which left women whose partners were MSM. 5) An exploratory Study was proposed for HIV and women whose partners were MSM. 6) The idea was expanded to include HIV negative women as well.

She stated the objectives of the study, as seen on the first page of the handout. In early 1995 two principle investigators were retained on a part-time basis to design the study. By the end of the summer the study design had been completed. Unfortunately one of the principle investigators resigned due to her lack of time. The AO staff -- primarily Valerie and Edd Brown -- provide in-kind services; drafted text for advertisements, discussed recruitment venues, etc. The amount of money spent in 1995 was $10,000 -- not including the AO in-kind services. At this point a community advisory board was recruited that consisted of researchers, community-based providers, and some HPPC members. The board contributed to the study design, identified more of the venues, recruitment strategies and they provided specific input about the areas of interest that should be explored.

The study began in January of 1996 with the one remaining principle investigator and Valerie as a co-principle investigator -- to ensure that the priorities of the HPPC were addressed in the study. Staff was hired in March of 1996 for a proposed six month period. That staff received extensive training for the exploratory phase. During this time they developed protocols, recruitment methods, forms, assisted with questionnaire design, conducted key informant interviews, and street and neighborhood observations, developed advertising text, identified venues, and many other important tasks. Due to numerous internal difficulties, all of those staff persons, including the principle investigator, were terminated. The study continued, led by Valerie and Irene Carmona. With Irene's help, experienced AO staff from various branches -- seroepi, research, and prevention -- replaced the terminated staff and began eligibility screening, active recruitment and interviews. These were conducted from July through October.

Valerie referred to the last page on the handout that listed some of the pre-screening preliminary data analysis. She explained that they had advertised for women who were sexually active and not specifically

FS/MSM, to avoid selection bias. She reviewed the statistics from the pre-screening preliminary data analysis and added that the data were comparable to the actual study population pertaining to age range, education, income, etc. She reviewed Section II, study aims, of the handout and explained that many of the objectives and areas of exploration came from the Community Advisory Board.

Valerie reviewed the methods employed to achieve the objectives of the study. Study personnel conducted a focus group, and in-depth phone interviews. The recruitment for both of these specifically targeted FS/MSM in order to gain valuable information that would direct the development of the final questionnaires. The study consisted of a convenience sample of all sexually active women. Their goal was to reach 40 women: 20 HIV positive and 20 HIV negative. They wanted the provision of over-sampling women of color and women younger than 25 years of age. She then reviewed the inclusion criteria. She pointed out that although the criteria required the women to speak and understand English, they had Spanish, Tagalog and Cantonese interviewers available. The only exclusion criteria was that participants not be employed by an AIDS service organization.

She referred to the second page of the handout Section III.B.4. She pointed out the list of possible venue identification recruitment sites. The intent was go to these places to post flyers, signs, and actually recruit women there. Key informant interviews with some of the merchants and other organization representatives were conducted by study staff prior to July. There were newspaper advertisements and presentations to community agencies, clinics, support groups, and social service agencies were made.

A 24 hour telephone line was available, which was not staffed 24 hours but had very specific message instructions. The pre-screening interview lasted 5 minutes. (The results of the pre-screening interviews can be seen on the last page of the handout.) Eligible participants were given information about their appointment options and advised of their compensation, $40.00 cash. At this point participants were also notified that the survey was anonymous and that it would be taped with their consent. The interview was semi-structured. It contained both closed and open ended questions. There were a total of 112 questions based on the eight Areas of Exploration – Section II.B. of handout. They planned on analyzing the closed ended data with simple statistics and then reviewing the open ended questions for re-occurring comments and common themes.

Valerie then referred to the results Section IV.C. of the handout. She stated that of the 227 women, 39 (17%) were eligible. Of the 39, 9 were HIV positive. 69% of the eligible women had heard about the study from advertisements. Valerie pointed out several limitations to their ability to make absolute statements about this sample; 1) the sample size -- only 39 women, 2) the method -- they blanketed the city with advertisements, and 3) the length of time of recruitment. She then reviewed the demographic data results. The mean age was 30; however, 36% were younger than 25 years of age. 44% were women of color. 27 (69%) of the women had between 12 and 16 years of education. 31 (80%) of the women were unmarried -- single not divorced or widowed. 85% rented. ¾ of the women were employed either part-time or full-time. 20 (51%) identified as heterosexual, 17 (43%) identified as bisexual, and 2 (5%) identified as lesbians. The mean income before taxes was $1,300/month, with the range being less than $500 to $2,000 a month. 59% had two or more sex partners who were MSM. Just over half (54%) reported not knowing that their partner was an MSM prior to their involvement. Almost all of them (92%) think that men should tell their partners about their sexual behavior. Some of the detailed reasons given for this last question were: because of risk, disease, and honesty/trust in a relationship.

When asked what these women did when they found out their partners were MSM, the majority said they did nothing. Some said the relationship improved, some said the relationship did not last, and the remainder said there was no change to the relationship. 87% had asked for his HIV status. 15 (38%) stated that their

partner had indicated that he had male partners during the relationship, 10 (26%) said they did not know. 22 of the women said their partner had other female partners. 15 (40%) said that the had not used protection with this partner. Out of these 6 never used protection with other partners. 27 (69%) perceived themselves at risk for HIV. 12 (31%) of the women had reported injection drug use. The women reported that 44% of their partners (MSM) had used injection drugs. 87 % reported being aware or participating in prevention programs. The most frequently cited sources for information were: media, health care provider, and friends. 90% of the women had been tested for HIV.

Valerie then referred to Section V. Lessons Learned. Some of the more notable comments or statements were that these women expressed a great deal of comfort discussing their sexual issues with their partners. In a 7 point comfort scale these women had a mean of 5.4. 12 of the women indicated that they dealt with their perceived risk by testing. When asked why they did not perceive themselves at risk, they reported; "their partners were not drug users, they had used condoms, he had told her he was HIV negative, I got tested, etc."

Valerie stated these FS/MSM were very willing to talk and were grateful that there was a study reaching out to them. The study shows that by using a variety of recruitment methods and strategies it is feasible to access this population. Women in this sample were very sexually active with high risk partners. They perceived themselves at risk yet 15 never used protection with this partner. They are also aware of testing as a prevention resource. Valerie had asked Viva Delgado if the Young Women's Survey (YWS), was finding FS/MSM. Viva responded that not many of the women in these low socioeconomic status neighborhoods were FS/MSM. However, Viva indicated that there was a 10% prevalence of Hepatitis C. This represents 31 women who were IDUs or whose partners were IDUs or who had sex with men. Approximately 15 women out of more than 300 with Hepatitis C, had partners who were MSM. She reiterated that this was a preliminary look at the results of the pre-screening and the study. She explained that they are planning to do more analysis of the data before they arrive at a final conclusion. Some preliminary conclusions are that we need to increase awareness through churches, enhanced media and peer networks. She extended her gratitude to the women who participated in the study, the Community Advisory Board, the HPPC, and all the people who supported and contributed to the study.

Tracey noted there were no public comment requests, therefore the Council could utilize the next 15 minutes for questions and comments to Valerie.

Maria asked for clarification on the study budget. Valerie responded that when the study was placed in the initial supplemental application it did not have a specific budget. There was approximately $140,000 allotted for the study. If the in-kind time spent by Irene and Valerie is removed, they spent about $70,000. Maria stated that she had been a part of the Community Advisory Group and she recalled that initially they had discussed a study sample of 200 women and 40 women for an exploratory study. She wanted to point out that after the internal crisis it was determined to use a study sample of 40 women instead of 200. The Community Advisory Board did not reach consensus about this decision. She added that the rotation of staff -- primary investigators -- also affected the study. Maria expressed another concern that so much money was spent on such a limited sample. She recommended that this be revisited at another meeting with the Community Advisory Committee members present. Valerie explained that initially the AO was bit overzealous. They proposed a large quantitative questionnaire with 15 areas of exploration and hundreds of questions. When they asked the Community Advisory Board for input they received their support and a recommendation that the AO begin with a focus group, the qualitative part, which would then inform the quantitative part of the study. There was a lot of consternation about that and the goal did change. She stated that they had looked at what the initial intent had been -- to do an exploratory study. If the findings of the exploratory study suggested feasibility to conduct the larger study and the resources were available,

it would have happened. It was not determined to be feasible, warranted or cost effective. This was communicated at the last Advisory Committee meeting. Even though few members attended a summary of the presentation, the findings, and the recommendations were sent to all Advisory Committee members.

Liz asked for clarification on the pre-screening preliminary data analysis (last page of handout). She asked about the 11% of women who reported trading sex for drugs or money; were these out of the 200 or the 40? *Note from Valerie: This was a typographical error. It should be 11%; 24 women out of 220.* Liz added that it seemed that the study did not really give any insight on FSMSM as a whole. Valerie responded that it may not, but what it did do is give some very valuable information that is not necessarily listed in these preliminary results.

Jimmie referred to the ethnic breakdown of the 39 women (Section IV.C). He pointed out that of the 39 women, 44% were women of color. The ethnic breakdown of that covers only 28.2 % (African American and Latina women), leaving a balance of approximately 12%. He asked what ethnicity it was. Valerie responded that there were mixed and other ethnicities. *Note from Valerie K.: African American = 6, Latina = 5, Asian /Pacific Islander = 2, Native American = 2, Mixed = 1, White = 23.*

Sonja pointed out that these preliminary results would not be very applicable for other individuals from the population of FS/MSM who don't know their male partners have sex with men. Ellen recalled a discussion with the principle investigators who came to CAPS trying to determine how to include individuals that would not identify themselves as part of that population. The principle investigators and CAPS researchers agree that it was difficult to determine effective methods to recruit this population.

Tracey thanked Valerie and Irene, then closed the meeting and reminded Council members to fill out the evaluations. She added that any other questions to Valerie and Irene could be addressed on the evaluations.

Distributed at This Meeting:

- San Francisco Castro Lions Club, JUMA Ventures & Castro Street Ben & Jerry's Ice Cream Store celebrates one year in business flyers,
- San Francisco Castro Lions Club, Third Annual "Till There's A Cure Fund-Raiser" flyers,
- "Process Evaluation Results" and "Participant Dialogue" boxes from the July 10, meeting,
- The Delta Project Information Handout.

Minutes Recorded by: Amalia Fernandez-Niewendorp, Polaris R & D, Inc.
Minutes Approved by: Tracey Packer and Valerie Kegebein, AO Staff, and Ellen Goldstein, Co-Chair.

HIV PREVENTION PLANNING COUNCIL MEETING

AUGUST 14, 1997
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer

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Please read: **Agenda**
***Please bring*: Agenda**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Food/Welcome/Introductions/Announcements	Ellen Goldstein	3:00 - 3:10 PM
2. Public Comment	Tracey Packer	3:10 - 3:30 PM
3. Prioritization of Unobligated Funds	Tracey Packer	3:30 - 3:55 PM
4. Criteria for Supplemental Funding	Valerie Kegebein & Tracey Packer	3:55 - 4:20 PM
5. Break		4:20 - 4:30 PM
6. An Introduction to the CDC Cooperative Agreement Application	Brian Dobrow	4:30 - 4:45 PM
7. Roles and Responsibilities Task Force Report	Jimmy Naritomi & Lyn Paleo	4:45 - 5:35 PM
8. Assessment Committee Update	Maria Rinaldi	5:35 - 5:55 PM
9. Closure/Evaluation	Ellen Goldstein	5:55 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC Meeting - Thursday, September 11, 1997, 3-6 PM, First Unitarian Church 1187 Franklin Street (@ Geary)

HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for August 14, 1997

* Please note in your calendar any of the following meeting times that apply to you: *

HPPC:	Thurs., Sept. 11, 3-6 p.m. at the First Unitarian Church
	Thurs., Sept. 25, 3-6 p.m. at the First Unitarian Church
Linkages Committee:	Mon., Aug. 18, 3-5 p.m. at the AIDS Office
	Mon., Aug. 25, 3-5 p.m. at the AIDS Office
Assessment Committee:	Mon., Aug. 29, 4:30-6:30 p.m. at the AIDS Office
	Fri., Sept. 5, 9-11 a.m. at the AIDS Office
Evaluation Committee:	Tues., Sept. 16, 5-7 p.m. at the AIDS Office

Members Present:
Barbara Adler
Marcos Bañales
Michael Discepola
Ellen Goldstein
Liz Highleyman
Jelousy Jiggetts
Valerie Kegebein
Sacul L'Adnbre
Sonja Mackenzie
Askia Muhammad
Jimmie Naritomi
John Newmeyer
Henry Ocampo
Tracey Packer
J. Colin Partridge
James Rapues
María Rinaldi
Steven Sams
John Blake West

Members Absent:
Elizabeth Davis
Deja Dior-Britt
Brenda Escobar
Kevin Gogin
Lisa Moore
Dawn Passar
Joel Reyna
Sandy Simms
Thomas Zickgraf

Leave of Absence
Ronnie (Chata) Ashley
Jennifer Lorvick
Bethsaida Ruiz

AIDS Office Staff:
Brian Dobrow
Delia Garcia
Marshia Herring
Mike Pendo

Guests:
Bernard Henderson, 3rd St. Prevention Program
Ramona Holloway, SF Black Coalition on AIDS
Cynthia Laird, BAR
Hank Wilson, ACT UP Golden Gate

Harder + Co./Polaris, Inc.:
Amalia Fernandez-Niewendorp, Polaris, Inc.
Lyn Paleo, Harder + Co.

HPPC Process Evaluation Team:
Pali Basi
Ruel Caneda
Raquelle Caras
Cely Queiroz
Kathleen Roe
Kevin Roe

1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Ellen convened the meeting shortly after 3:00 p.m. and asked that members and guests introduce themselves. She welcomed everyone and asked if there were any announcements.

Announcements

Steven Sams

- The San Francisco Castro Lions Club Third Annual "Till There's A Cure Fund-Raiser," Giants game will be August 31. Tickets are still available to the Giants vs. the Anaheim Angels; Sunday, August 31, at 1:05 p.m. All seats are lower reserved on the first base side of the field. The cost is $15.00 per ticket. They are available from him or they may be ordered through either Michelle Jester at 510-901-6308 or at 584 Castro Street, BOX 200, San Francisco, CA 94114.

Ellen Goldstein

- Flyers and leaflets were distributed -- in both Spanish and English -- pertaining to the UCSF California Partners Study. It is intended for Magnetic (one HIV +; one HIV-) Heterosexual Couples.

- Ellen read and distributed a letter and a poem from Chata. Chata's partner, Kurt Weeks, passed away August 19. If you wish to send a card or something to Chata, please send it to his home address.

- Ellen indicated that Vic Hernandez had sent a letter of resignation to the Co-Chairs, per his request, she read the letter to the Council.

Jimmie Naritomi

- The CDC HIV Prevention Update on Guidelines for Prevention Case Management and Partner Notification -- a Public Health Training Network Satellite Broadcast will be aired on October 23, 1997, 1:00 - 3:30 p.m. EDT. This interactive broadcast presents an update on past and present research and programmatic guidance on HIV partner notification and prevention case management. Viewers will be invited to call in questions and comments during the broadcast; they may also submit questions by fax before, during, and after the program or by e-mail following the broadcast (see attached handout No. 1).

John Newmeyer

- John distributed "Mid-City Numbers." This is a written record of the oral presentation made at the July 24 Council meeting pertaining to the Consensus Meeting preliminary results (Jul. 24, Council Meeting). The document includes a discussion of HIV and age that was not part of his presentation. (See Handout.)
-

J. Colin Partridge

- John announced that a collaborative conference between himself and a professor at Sonoma State University has been funded. The HPPC had written a letter of support for this project and though it was not funded by the original sources, it has been funded.

Kathleen Roe

- Due to the variety of topics being presented today, the evaluation form was divided into presentation sections. Kathleen gave brief description of each of the evaluation forms: Evaluation, Participant Dialogue, and Three Words (mid-year check-in). Members were instructed to evaluate each presentation separately, after each was completed.

Tracey Packer

- The Steering Committee will be meeting on Wednesday, August 20, from 3:00 - 5:00 p.m., at the AIDS Office.

- The AO has recently experienced some difficulties in the distribution of minutes and other materials. Tracey apologized and ensured the Council that the AO will make every effort in the future to distribute these items and any pertinent information to the Council members as quickly as possible.

Jelousy Jiggetts

- A flyer was distributed pertaining to the San Francisco Black Coalition on AIDS and the Bay Area Black Journalist Association Town Hall Meeting and Community forum. Entitled The Changing Face of AIDS in the African American Community, this event is scheduled for August 16, 1997, from 10:00 a.m. to 2 :00 p.m., at the Bayview Opera House.

2. PUBLIC COMMENT

Tracey introduced this agenda item by reviewing the rules for public comment. She explained that all speakers must fill out a registration form. Each speaker has three minutes and will receive a 30-second warning from the co-chairs. Tracey introduced speaker *Hank Wilson of ACT UP Golden Gate.*

- *Past Public Comment Correction:* Hank indicated a correction to information he presented at the July 10, Council meeting. The HIV testing in Los Angeles is providing results to their clients within *one week* -- not within 24-hours as he previously stated. He added that a recent article in the Journal of AIDS discussed a Texas study that addresses this issue. The study findings indicate that clients are interested in getting their results as soon as possible and that this approach did not cost more money than the current turnaround time.

- *Poppers Advertisements and Promotion:* Hank extended his gratitude to Steven Sams for writing and publishing an article in the Castro Street Lion Youth Newsletter about poppers. The article raised the issue of poppers and HIV and made it clear that information and answers to questions were available. He pointed out that there had already been some response to the article and that the company that was promoting the advertisements in the newspapers has stopped selling their ads. He stated that this is a demonstration of how cumulatively we can make a difference. Hank added that there is an educational poppers brochure that has been designed and is currently in the process of being developed for citywide dissemination.

- *Qualitative Vs. Number-Driven Research:* Hank referred to a recent CAPS study that indicated that risk factors for seroconversion among gay men include poppers and speed use. He added that there are several qualitative studies that demonstrate these and various other factors that affect individuals' ability to engage in safe behaviors. He urged the Council to support more qualitative studies – including cultural and anthropological context -- rather than the number-driven studies that Federal and State governments favor. He added that this type of qualitative data will provide an understanding that will allow for adaptation and modification of the prevention messages.

- *PEP*: Hank indicated that PEP has begun reaching and possibly affecting San Francisco communities. He urged the Council to solicit the involvement of the DPH in developing appropriate measures to deal with PEP. He pointed out the need for clear media messages about PEP and some form of mitigation for the possible ramifications to the prevention efforts of the City. This issue is problematic in that at this point, the media, outreach, and mitigation pieces are not in place, yet PEP has already been launched into communities. He stated that in a recent issue of the New England Journal of Medicine, a letter claimed that PEP was already affecting individuals in that they are no longer practicing safe behaviors.

HPPC Response to Public Comment:

Valerie agreed with Hank that PEP and other treatment modalities can affect risk behaviors. She stated that there will be a more concerted effort to ensure that the existing prevention messages are reinforced. The PEP message will include known information about PEP, pros and cons. She will be joining the Community Advisory Board (CAB) as an AIDS Office representative and is looking forward to the possible collaborative efforts between the HPPC and the CAB to develop comprehensive and appropriate messages about PEP. This collaboration would help minimize any potential harm from PEP and would maximize whatever the PEP outcome is going to be. Valerie stated that she will be working with Josh

Bamburger and the CAB to ensure that appropriate prevention messages are included with other PEP information and gets off the ground as rapidly as possible.

3. APPROVAL OF JULY 10, AND JULY 24, MINUTES.
Tracey asked if anyone had questions, comments or corrections on the minutes. There were none, and the minutes of 7/10 and 7/24 were approved.

4. PRIORITIZATION OF UNOBLIGATED FUNDS
Tracey gave a brief summary of the unobligated funds process thus far. She stated that at the July 10 Council meeting the Council had discussed and agreed to send a letter of concurrence for the Detuned Assays and the Young Women's Survey, with a stipulation that the HPPC would require additional time for requesting the balance of the unobligated funds. At the July 24 meeting, the Council discussed and agreed to send a letter of concurrence requesting the balance of the unobligated funds for one time costs, up to $100,000, identified in the supplemental funding priorities set by the Council with the balance of the funds ($66,000), to be spent on a list of suggestions that were under discussion: 1) African American gay and bisexual men's study, 2) Latino gay and bisexual men's study, 3) Town Hall Meetings, 4) Peer Education Training, and 5) Funding for Perinatal AIDS Services in San Francisco.

Tracey indicated that the AO had analyzed the above list of suggestions for feasibility of one time costs. She explained that the requirements of the supplemental funding are that it be a one time cost and that is spent by December 31, 1997. She presented the AO recommendations to the Council and explained that the Council needed to determine which of the options they would recommend funding. Once the Council has voted on which of these five options they wanted to approve as HPPC priorities, the AO staff will determine what can be funded with the amount of funds that are available.

- ***African American gay and bisexual men's study***: The amount of time required to design, develop, and recruit for a sound study would surpass the allotted time.

- ***Latino gay and bisexual men's study***: Since the study is already in progress, additional funding would not be necessarily helpful. It was unclear if they could spend the funding in the allotted time, and it was not something they requested.

- ***Town Hall Meetings:*** This is a feasible option. However, it requires immediate attention if chosen due to the time allotted. It would require immediate planning, recruiting, advertisements, etc.

- ***Peer Education Training:*** This is a feasible option. In order to get the funding spent by December 31, 1997, the training would have to be done through one of the DPH programs. Since the funding is in the DPH it could easily be done through one of the two youth programs, WEDGE or Youth United through Health Education.

- ***Funding for Perinatal AIDS Services in San Francisco***: This may not be a feasible option. The request was for funding staff, which is not a one time cost, therefore the CDC would not be in favor of this option.

HPPC RESPONSE TO AO RECOMMENDATIONS:
African American gay and bisexual men's study
In response to a question, Ellen explained that this option had been proposed based on the prioritization of the Research and Evaluation Committee -- it was listed as their first priority. She added that she

agreed with the AO recommendation that there would not be enough time to complete this study by December 31, 1997. There were no objections to the AO recommendation for this option.

Latino gay and bisexual men's study: Tracey explained that this option was similar to the previous option in that it would require more time to complete than was allotted. She added that the issue of funding a project which is outside the AO and not an existing DPH program, was also problematic. She explained that the amount of time that it takes to process contracts would hinder the feasibility of completing allocation by December 31, 1997. There were no comments or objections to the AO recommendation for this option.

Town Hall Meetings: Tracey suggested that a Town Hall meeting could also be held in conjunction with the Mayor's Summit on AIDS -- scheduled for December 2, 1997. Sonja pointed out that the original suggestion for the Town Hall meetings had been to facilitate community involvement in the HPPC. By conducting a Town Hall meeting geared towards the Mayor's Summit on AIDS, the intent of the original suggestions would be lost. John indicated that there were other possibilities to facilitate community involvement with the HPPC, e.g., public opinion polling, focus groups, Internet chat rooms, letters to the editor, etc. Jelousy pointed out that although he agreed that web sites are effective, not everyone has access to them. Liz stated that the Human Rights Commission had recently asked that the DPH collaborate with them in an effort to address the issues of sex clubs and bathhouses. She added that this could be the topic of a Town Hall meeting discussion. Some of the other suggestions discussed for a Town Hall meeting were: HIV and women, PEP, queer youth, poppers, Consensus Meeting Data, and the intersection between prevention and treatment.

A discussion followed about the amount of money that could be used for the Town Hall meetings. It was suggested that we attempt to find donated space, etc., to stretch the funding as much as possible. Jimmie suggested that the notion of a Town Hall meeting in conjunction with the Mayor's Summit on AIDS would be a great opportunity for the HPPC to collaborate with the CARE Council. The two Councils could share the cost and address both sides, prevention and treatment.

Tracey stated that in the discussion about Town Hall meetings, members seemed to be interested in facilitating community involvement in general with the HPPC. She suggested that instead of calling this option "Town Hall meetings," they might refer to the option as "Community Forums." This would allow for the various possibilities that had been suggested. This option was supported by the members present.

Peer Education Training
The members discussed the implementation of the Peer Education Training. They discussed whether the recruitment and training of youth would be through the two DPH programs or through community based organizations. Several members agreed that there should be some commitment or agreement that the graduates of the training are given the opportunity to use the training to provide some sort of service; prevention, advocacy. One member pointed out that this option might be difficult to fulfill since it could take some time to do the recruitment and training of enrollees. Tracey stated that the Council could stipulate that more than just the training be funded. One possibility could be to have the DPH working with a consortium of youth agencies to develop the training and the implementation with the Council stipulations.

In response to a question, Tracey explained that this funding would have to be obligated, as well as invoiced, by December 31, 1997. She pointed out that these funds were different from the supplemental funds, that only required that they be contracted by December 31, 1997. The amount of funding that was discussed for this option was approximately $5,000. Tracey added that initially the Council had

suggested paying a stipend to the peer educators during their training. Tracey emphasized that the funding figures that were being discussed were strictly ballpark. The intent of this discussion was to determine which of the options could be prioritized.

Funding for Perinatal AIDS Services in San Francisco: Tracey explained that this option would not fit the eligibility for these funds. Colin stated that he agreed that this was not a feasible option. The type of funding that is being requested is for staffing, which is not a one time cost. Tracey added that BAPAC had received some augmentation from the CARE Council. Barbara stated although BAPAC could not be funded, she was in favor of a continued dialogue pertaining to perinatal transmission of HIV and perinatal HIV prevention efforts. Steven asked if there were any other ideas for one time funding possibilities that would address perinatal AIDS services. Colin agreed that he could look into the possibilities and report back to Valerie.

Tracey summarized that the Council had agreed to the following three options: Peer Education Training, Community Forums (previously identified as Town Hall Meetings), and possible funding for perinatal AIDS services in San Francisco. She then asked members for a show of hands as to their preference of prioritization.

Peer Education Training:	Six (6) members wanted this option as first priority.
Community Forum:	Nine (9) members wanted this option as first priority.
Perinatal Services:	Zero (0) members wanted this option as first priority[1].

Tracey summarized that the prioritization order would be: 1) Community Forums, 2) Peer Education Training and 3) Possible Funding for Perinatal AIDS Services in San Francisco. Tracey explained that the AO staff will review and report back to the Council regarding the funding levels and any response from CDC.

Ellen offered a reiteration of the unobligated funds process, which has included three phases over the last couple of months (Jul. & Aug.). **Phase I**: Council approved letter of concurrence for the YWS and Detuned Assays. **Phase II**: Council approved letter of concurrence for the $100,000 to media and other one time costs in the supplemental priorities, and $66,000 to the list of prioritized one-time costs. **Phase III**: Council approved the prioritization of the one time cost options[2].

4. CRITERIA FOR SUPPLEMENTAL FUNDING

Tracey and Valerie presented the draft of the Process for Augmentation for CDC Supplemental Funding 1997 (attached handout No. 2). Tracey explained that the AO had faxed this draft to Council members for feedback, but had only received three responses, which had been incorporated. She stated that those who had not been able to provide their feedback previously could do so during the overhead presentation. She distributed a handout of the overhead presentation and reiterated that it was only a draft. Tracey stated that the augmentation process would included six steps, A through F. She read through each of the steps and then asked the Council for their input. A discussion followed with members' comments, questions, and feedback. These are listed below.

A: The AIDS Office will review all existing prevention contracts and proposals to RFPs 015 and 016 to determine if they meet the eligibility criteria, 1, 2, 3.

[1] A show of hands (all members present) indicated that the Council wanted this option to be included in the funding.
[2] This last phase is merely to advise CDC of the options chosen by the Council.

Criteria 1: Jimmie recalled that some of the priorities had been prioritized by the interventions. He asked for clarification as to why the AO may select contractors or agencies that had no experience with the interventions. Tracey responded that the AO staff had discussed that issue, and had determined that currently there were no contractors or agencies providing the specific interventions to the specific populations, thus the gaps identified by the Supplemental Task Force. The AO had concluded that it was more important to have expertise with the population because it would be easier to develop the interventions, rather than the relationship with the population.

Jimmie explained that he was not convinced that the existing AO contractors were best suited to provide services to all of the priority populations stipulated. He asked for clarification as to what would happen if the AO could not identify a contractor or agency with the experience and ability to provide the services. Tracey responded that this would then require a RFP. Ellen reiterated that the supplemental funding decision had been to include two mechanisms for distribution of the funds: contract augmentation and RFPs. The intent of the contract augmentations was to get the money out as quickly as possible. She added that this presentation was strictly about the contract augmentation mechanism.

Valerie added that the goal of the AO was to get all of the 1997 funding distributed as quickly as possible through the contract augmentations, since a RFP would delay the distribution of funding. The AO staff had discussed addressing interventions and populations **not** funded through the contract augmentations, through RFPs with the 1998 funding. She explained that the AO had researched the existing contractors and agencies and felt confident that many of the contractors and agencies could provide the services.

Criteria 2: Liz asked for clarification on how likely it was for contractors and agencies to not meet at least 90% of their Units of Service (UOS). Valerie responded that the range of UOS was between 18% to 207%. The AO staff felt that the 90% being stipulated in this criteria was too high. A key point was that some agencies spent their first two quarters in start-up tasks, and their units of service were not planned to be conducted uniformly across all quarters. Many of the existing contractors and agencies might be ruled out. The intent of this criteria had been to determine fiscal capability and ability of the contractors and agencies. The AO staff are open to consider lowering that percentage to allow more agencies to be eligible. A discussion followed in which members discussed both raising and lowering the percentage. Some members felt that 90% was a feasible request, others felt that it would be too restrictive, and some felt that a median of the highest and lowest current percentage would be acceptable. The Council was unable to reach agreement about this issue. Tracey stated that the AO would take the comments and suggestions under advisement and consideration.

Criteria 3: Barbara asked for clarification on how the AO would deal with agencies that did not have a past contract. Tracey explained that those who did not have a previous contract would have fewer criteria applied to them. Mike pointed out that currently there were only two providers that did not have previous prevention contracts.

B: The AIDS Office sends a letter to those contractors and agencies who meet the above mentioned eligibility criteria. *(NOTE: Members did not have any comments, suggestions or questions pertaining to the following sections: B.3.d, B.3.f, and B.3.g of this step.)*

Tracey explained that this letter would inform eligible contractors and agencies of the amount of funding available for the specific interventions and populations that would be served. The letter would also request that interested contractors and agencies submit a letter to the AO with specified information (see attached handout No. 2.) She read through the specified information and then asked the Council for input.

B.3.a: Jimmie pointed out that the last RFPs -- 015 and 016 -- had required that applicants provide two years experience as part of that process eligibility criteria. He asked for clarification on whether these same applicants would have to re-submit this eligibility criteria again. Tracey explained that the RFP's 015 and 016 criteria had been for other populations and interventions. This eligibility criteria would have to pertain to these supplemental funding specified interventions and populations.

B.3.b: Members asked for clarification pertaining to the three methods of demonstrating cultural competency. Tracey explained that contractors or agencies could either provide evidence of staff and board demographics reflecting representation of the target population or evidence of involvement of target/behavioral risk population in planning the intervention, as demonstrated by use of evaluation data, client satisfaction reports, and focus groups data in program design and modification.

Maria expressed her concern about leaving the third option to stand alone as evidence of a contractor's or agency's cultural competency. She stated that the type of evidence that was being requested in this option did not actually address the issue of cultural competency. Other members expressed their support for this third option. They suggested that this option allowed newer contractors and agencies -- who might be in the early stages of development -- to demonstrate how they would solicit community involvement for their interventions and planning process. Sacul, as chair of the Linkages Committee, mentioned that since cultural competency was more than just about race and ethnicity, this third option also provided a manner to address the broader issues of cultural competency.

B.3.c: John indicated that the use of the word 'willingness' in this section was unclear. He suggested the need to be more specific about the intent of this section. Tracey agreed to modify this by using clearer language about how the contractors or agencies would implement the interventions.

B.3.e: Liz indicated that this section was a bit ambiguous as to whether the majority (minimum of 75%) of the funds needed to be spent on staff alone, or if it could include media, incentives, etc.. Tracey stated that the AO would take that information into consideration, before finalizing the document.

C: Letters from contractors and agencies will be reviewed for evidence of the above criteria.
It was recommended that an additional step be added that could address the final decision process. Tracey agreed and stated that this step would be followed by an additional step requesting eligible agencies to describe how they plan to implement the intervention(s).

(NOTE: Members did not have any comments, suggestions or questions pertaining to the following steps: D. E., and F.)

Tracey and Valerie thanked the Council for their patience and participation. Tracey explained that the AO staff would now take all of the information discussed at this meeting into consideration. She added that at the September 11 meeting, the AO would present to the Council which contractors and/or agencies had been augmented or as much information had been determined by that time.

5. BREAK

6. CDC COOPERATIVE AGREEMENT APPLICATION
Ellen stated that before the next meeting all Council members would be receiving a copy of the CDC Cooperative Agreement Application. She explained that the Council would be voting whether to

authorize a letter of concurrence for this application at the next Council meeting. She introduced Brian Dobrow of the AO.

Brian explained that he would be providing a brief introduction about the application in order to familiarize the Council members with the document before they receive it. He indicated that the CDC Cooperative Agreement Application is something the AO is required to put together each funding year. He stated that it is a non-competitive proposal in which the AO knows the specific funding amount. He indicated that the past budgets have totaled $7.4 million. With the supplemental funds that have been added this year, the January through December 1998 budget request is over $8.1 million.

Brian explained that the application includes three major components. The first major component is the Annual Progress Report. This report includes the following sections: a) Community Planning Objectives, b) National Core Objectives -- see attached handout No. 3, c) 1998 Community Planning Objectives, d) Additional Plans for Achieving the National Core Objectives, and e) Summary of Key Elements in the Current HIV Prevention Plan. Brian indicated that the 1998 Community Planning Objectives have not yet been changed by this Council, therefore the application will simply repeat the Community Planning Objectives for 1997.

Brian indicated that the next component is the HIV Prevention Program Annual Report on Programmatic Activities and Proposed 1998 Prevention Program Objectives and Activities. He explained that this section deals with the type of program areas being funded throughout the City (e.g., CTRPN, Health Education/Risk Reduction, Public Information, Evaluation and Research, Capacity Building, Training and Quality Assurance, and Other Activities.) He added that these program areas are found within the Department of Public Health and in Community Based Organizations.

Brian explained that the last component included the Line Item Budget and the Narrative Budget Justification. This section must also include a letter of concurrence or non-concurrence from the HPPC pertaining to the program priorities contained in the application. He indicated that Council members could anticipate receiving the Scope of Work for 1998, the Budget Summary (if completed), and the Progress Report - last nine months. He recommended that the Council members thoroughly review the information they will receive to assure an informed and efficient process at the September 11 Council meeting.

In response to a question about the application deadline, Brian informed the Council that the application is due on October 3, 1997. This requires that the final application be placed in the mail by September 26, 1997. If modifications to the application are required, the Council would have the opportunity to vote on a revised application at the September 25 Council meeting. John asked for a summary of the unmet objective areas from last year. Brian explained that they were primarily in the evaluation and behavioral research areas, due to the fact that not all of the studies which had been anticipated had been completed. The Public Information objective area has not yet been achieved at this time (August) due to the lack of available staff time. Brian added that all of the critical areas had been met.

7. ROLES AND RESPONSIBILITIES TASK FORCE (RRTF) REPORT

Ellen introduced this section of the agenda. Due to the limited amount of time, Jimmie would present the first half of the scheduled presentation, 'the context.' Lyn would then present the other half of the presentation 'the content' at the September 11, Council meeting.

Jimmie explained that the RRTF had not experienced a very smooth process. The lack of membership continuity from one year to the next ('96 to '97) due to the changes, conflicts and disputes the Council,

AO and DPH went through left the task force struggling to complete their task. He indicated that the last Council and its committees had faced some very difficult issues around the implementation and development of the HIV Prevention Plan. Because of the many issues that erupted, the previous Steering Committee determined the need to reestablish what the community planning process was all about. They stipulated the need to take a proactive approach towards clarifying the roles and the responsibilities of each of the partners of this collaboration; HPPC, AO and DPH.

Jimmie stated the areas of initial concern:

- The specific responsibilities of the HPPC versus those of the AO and the DPH -- other than the general guidelines provided by the CDC regarding Community Planning Processes.
- The shared responsibilities between the HPPC, AO and DPH. The involvement of Council members in the decision making process at all levels.
- The mechanism for mutual accountability and effective communication with each other, including communication regarding changes by the AO prior to implementation of Council approved recommendations.
- Mechanism for disputes, disagreements and grievances.

He then indicated the primary expectations of the RRTF.

- Clarify the current roles and responsibilities as well as provide a clearly defined written documentation for future guidance as general operating policies and procedures.

- Establish a more effective collaborative partnership to achieve a better working relationship between the HPPC and the DPH by:

    a) Reestablishing a better sense of being a part of the whole community planning process versus the current concept and general feeling of "we against them."

    b) Improving communications particularly regarding the decision making process by both the HPPC and AO and ultimate changes of approved recommendations by the full Council prior to actual implementation by the AO.

    c) Effectively dealing with conflict resolution whether or not any issues may be a majority or minority opinion of the Council. *(Jimmie added that the exclusion of the AO in this section was a result of the separate policies and procedures that apply to the AO staff. The Council can not dictate to the AO internal matters that are determined by the DPH.)*

    d) Appropriately utilizing the Letter of Concurrence or Non-Concurrence with any CDC applications as a mechanism of last resort to resolve disputes or disagreements.

Jimmie explained that the Roles and Responsibilities document, which consist of 15 pages, includes a clear and concise overview of the reasons for the establishment of this Task Force as well as their endeavors to create the document (refer to page 1 of the document). The primary responsibilities of the HPPC and DPH AO have been clearly outlined. He pointed out the importance of Council members understanding the stated final authorities that have been approved by the Task Force, the AO and the Director of the AO, after a year of deliberations with various offers and counter offers. He emphasized the fourth paragraph of the first page of the document that states: "The HPPC has final authority over

establishment of HIV prevention priorities. The DPH has authority over the implementation of these priorities; as an advisory body, the HPPC makes recommendations to the DPH."

Jimmie stated that twelve key areas had been identified in the process of creating this document. Some of the most difficult and problematic areas were: the implementation of priorities and recommendations, other implementation activities, communication, mutual accountability, conflict resolution and grievance procedures. He thanked the Council for their patience and welcomed any input they might provide. He clarified that the Council is not being asked for a vote of approval on the document since the Task Force was charged with creating this document.

Maria asked for clarification as to how the document could be a product of the Council if it has not been approved by the full Council. Jimmie explained that this Task Force had been established by the HPPC for the sole purpose of developing this document. The Task Force had consisted of HPPC members, Co-Chairs, AO staff, Technical Support staff and Process Evaluation staff. This was a joint effort to create something that could be useful, but by no means is this document absolute.

Ellen added that the Task Force welcomes any input and they will modify the document as possible. However, there are certain areas that the AO has authority over. Although there will not be a vote on the document, we encourage discussion and input that will result in Council approval. Jimmie added that the document is currently being reviewed by Mitch. It is not expected that there will be any significant changes, however, the document is the result of work between the DPH, AO, and HPPC representatives. Maria expressed her concern that if this is to be a document that guides the Council's work, then it should be approved by the Council. She requested that the Co-chairs place this on the future meeting agenda for a deeper discussion and vote.

Barbara offered a point of clarification. She understood that most of the information in this document has been an effort in research and clarification for a process that the Council did not have documented. She feels that it is not so much a newly created document but rather a clarification of the CDC document. Ellen summarized that this would be discussed at the next meeting.

8. ASSESSMENT COMMITTEE UPDATE

Tracey introduced Maria Rinaldi, Chair of the Assessment Committee. Maria distributed a handout on the Four Phases of the Priority-Setting Model. She explained that the Assessment Committee had spent the last several months discussing many of the issues the last Council faced pertaining to the Priority-Setting Model. Maria added that one of the issues the Committee had identified as a priority was the need to include the co-factors into the model.

Maria indicated that after several meetings, the Committee determined the need to reach some consensus about the fate of the Priority-Setting Model. A concept vote determined that the Committee would revise the existing model, not discard it. The Committee then agreed to invite presenters from the community; researchers, epidemiologist, etc., to provide the Committee with some information, input and discussion pertaining to the different components of the Priority Setting Model. The intent of having these presentations was not to make any decisions or resolutions, but rather for the Committee to listen and explore the ideas and suggestions of how the Committee could revise and improve the existing model. She summarized the different presentations the Committee had received.

- *Presenters Cynthia Gomez, and Kerrington Osbourne*: Presented a historical overview of the development of the Priority-Setting Model.

- *Presenter Rafael Diaz, CAPS*: Presentation on how culture sets a context for behaviors.
- *Presenter Dennis Osmond, SFGH and CAPS*: Presentation on the epidemiological perspective.

After a brief discussion pertaining to the content of the presentations, Maria indicated that the meeting minutes were available for Council members who were interested in the details of the presentations. Tracey added that anyone interested in receiving copies of the Assessment Committee meeting minutes should contact her at 554-9992.

9. CLOSURE/EVALUATION

Ellen thanked all of the presenters and asked that members complete their evaluation forms before leaving.

Attached to these minutes for all members:

- Handout No. 1 - CDC HIV Prevention Update on Guidelines for Prevention Case Management and Partner Notification flyer.
- Handout No. 2 - Process for Augmentation for CDC Supplemental Funding 1997
- Handout No. 3 - National Core Objectives

Attached to these minutes for absent members:

- UCSF, California Partners Study flyers (In Spanish and English).
- Letter and poem from Chata.
- "Process Evaluation Results" and "Participant Dialogue" boxes from the July 24, meeting.
- SFBCA/BABJA, Town Hall Meeting and Community Forum flyer.
- Roles and Responsibilities Document.
- Four Phases of the Priority-Setting Model

Minutes Recorded by: Amalia Fernandez-Niewendorp, Polaris R & D, Inc.
Minutes Approved by: Ellen Goldstein, Community Co-Chair and Tracey Packer, DPH Co-Chair

HIV PREVENTION PLANNING COUNCIL MEETING

SEPTEMBER 11, 1997
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

97

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Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer

Please read: **Agenda/Cooperative Agreement Application & Roles & Responsibilities Document**
Please bring: **Entire Package**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Food/Welcome/Introductions/Announcements	Tracey Packer	3:00 - 3:10 PM
2. Public Comment	Ellen Goldstein	3:10 - 3:30 PM
3. Roles and Responsibilities Report (Part 1)	Ellen Goldstein Jimmy Naritomi	3:30 - 4:10 PM
4. Supplemental Funding Update	Valerie Kegebein	4:10 - 4:40 PM
5. Evaluation		4:40 - 4:45 PM
6. Break		4:45 - 4:55 PM
7. CDC Cooperative Agreement Application (Vote on Letter of Concurrence/Non-Concurrence)	Brian Dobrow	4:55 - 5:55 PM
8. Closure/Evaluation	Ellen Goldstein	5:55 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC Meeting - Thursday, September 25, 1997, 3-5 PM, First Unitarian Church 1187 Franklin Street (@ Geary)
Thursday, October 9, 1997, 3-6 PM, First Unitarian Church 1187 Franklin Street (@ Geary)

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HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for September 11, 1997

* Please note in your calendar any of the following meeting times that apply to you: *

HPPC:	Thurs., Sept. 25, 3-5 p.m. at the First Unitarian Church
	Thurs., Oct. 9, 3-6 p.m. at the First Unitarian Church
Linkages Committee:	Mon., Sept. 15, 3-5 p.m. at the AIDS Office
	Mon., Sept. 29, 3-5 p.m. at the AIDS Office
Assessment Committee:	Mon., Aug. 29, 4:30-6:30 p.m. at the AIDS Office
	Fri., Sept. 5, 9-11 a.m. at the AIDS Office
Evaluation Committee:	Tu., Sept. 16, 5-7 p.m. at the AIDS Office

Members Present:
Barbara Adler
Ronnie (Chata) Ashley
Elizabeth Davis
Michael Discepola
Brenda Escobar
Ellen Goldstein
Liz Highleyman
Jelousy Jiggetts
Valerie Kegebein
Sacul L'Adnbre
Sonja Mackenzie
Askia Muhammad
Jimmie Naritomi
John Newmeyer
Henry Ocampo
Tracey Packer
Colin Partridge
Dawn Passar
Joel Reyna
María Rinaldi
Steven Sams
John Blake West

Members Absent:
Marcos Bañales
Kevin Gogin
James Rapues
Sandy Simms
Thomas Zickgraf

Leave of Absence
Jennifer Lorvick
Bethsaida Ruiz

AIDS Office Staff:
Brian Dobrow
Delia Garcia
Marshia Herring
Mike Pendo

Guests:
Loraine Ashley
Tamara Ching, Southeast Asian Community Ctr.
Christopher Smith, New Village/NTFAP
Stacy Vogan, STD/HIV Prevention Training Ctr.
Joshua Volle, STD/HIV Prevention Training Ctr.

Harder + Co./Polaris, Inc.:
Amalia Fernandez-Niewendorp, Polaris, Inc.
Rick Green, Harder + Co.
Lyn Paleo, Harder + Co.

HPPC Process Evaluation Team:
Pali Basi
Ruel Caneda
Raquelle Caras
Cely Queiroz
Kathleen Roe
Kevin Roe

1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Tracey convened the meeting shortly after 3:00 p.m. She asked that members and guests introduce themselves. She welcomed everyone and asked if there were any announcements. She welcomed Chata back after his leave and noted that a candle was set out n memory of Chata's partner of 23 years, Kurt Weeks.

Announcements

Sonja Mackenzie

- Flyer distributed from LIFE: California's Lesbian/Gay & AIDS Lobby & Institute. The flyer pertained to a recent Lesbian/Gay Bisexual Civil Rights Bill (AB 257) that passed at the State Senate and is on its way to the Governor's Desk for a signature or veto. Individuals interested in voicing their support of the proposed legislation may write to: Governor Pete Wilson, State Capitol, Sacramento, CA 95814.

- She indicated that a community forum is being arranged for October 8, 1997, to discuss the CDC HIV Prevention Update on Guidelines for Prevention Case Management and Partner Notification -- a Public Health Training Network Satellite Broadcast that will air on October 23, 1997, 1:00 -

3:30 p.m. EDT. For more information please contact: Eileen Hansen, at the AIDS Legal Referral Panel. 415-291-5472.

Steven Sams

- Notified Council members of the 'Brothers for Sisters' campaign to benefit the Lyon Martin Women's Health Services. On Friday, September 26, 1997, at the City Club of San Francisco. The 'Brothers for Sisters' campaign will be honoring Hazel Betsey and Diane Jones, RN for their outstanding contributions to health and civil rights. Invitations are available through Steven for individuals interested in participating.

- Steven indicated that the were invitations available to join the Pacific Bell Team, at the 1997 Susan G. Komen Breast Cancer Foundation's 'Race For The Cure.' The October 19, 1997 race consists of a 5K Men's/Women's Run and a 5K Fun Walk. For more information call Pacific Bell External Affairs: 415-394-3707.

- Steven stated that Hank Wilson had prepared and provided him with an annotated bibliography pertaining to Poppers (Nitrate Inhalants) and HIV. Steven apologized that he had not made copies for distribution to the Council, but indicated that he would make the document available to anyone interested.

- Steven reported that the latest Castro Lion Newsletter (Vol. V - Issue 19 1997) was available to any interested members.

- The San Francisco Castro Lions Club is accepting orders for the 'Entertainment '98 Books.' Editions are available for several different counties. Book costs based on the specific Counties and range between $25 and $40 to benefit the Castro Lions Club's AIDS Charity Fund. For more information call 415-90-LIONS (5-4667.)

Kathleen Roe

- Kathleen thanked Council members for their patience and participation in the last meeting evaluation. Kathleen referred to the last page of the August 14, Evaluation Results -- 'Three Words.' She stated that this exercise -- that served as a mid-year check-in from Council members -- had mixed results. Each is listed by respondent, then aggregated to re-categorize them into two separate groups. The larger box depicts the group of positive expressions listed by the respondents while the smaller box depicts the group of 'red flags' that need to be taken into consideration. She also noted that the Council should begin looking at the Parity, Inclusion and Representation (PIR), to determine how the Council is meeting those standards.

Elizabeth Davis

- Youth United Through Health Education has an opening for a part-time (15 hours per week), Peer Educator. The position offers the opportunity to learn and share information about HIV and STDs, through street based outreach, workshops and counseling. Applications are due by Friday October 3. For more information call 554-8472.

Tracey Packer

- Noted that Liz Highleyman will be arriving late, Brenda Escobar will be departing early, and Marcos Bañales is on vacation.

- Tracey distributed John Newmeyer's 'Mid City Numbers.' She indicated that this document was a summary of the May '97 Consensus Meeting on HIV Prevalence and Incidence in San Francisco.

Chata Ashley

- Chata thanked everyone for the warm sentiments and wishes he received during the past months. He stated that he is looking forward to getting back into his work and thanked everyone for continuing their hard work during his absence. He specifically thanked Sacul for her determination and dedication with the Linkages Committee during his absence.

- Chata indicated that he was glad to return on a day that was so significant to this Council -- the vote on the CDC Application and the discussion of the Roles and Responsibilities document. He indicated that the AO Director, the AO Prevention Unit, and several Council members worked very hard to develop this document. It is a stepping stone for this and future Councils.

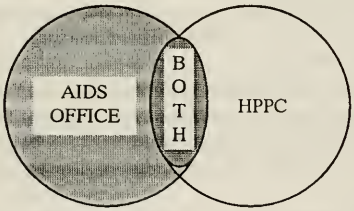
2. PUBLIC COMMENT

Ellen introduced this agenda item. She indicated that the Co-Chairs had not received any Public Comment request, therefore she suggested moving on to the next item on the agenda.

3. ROLES AND RESPONSIBILITIES TASK FORCE (RRTF) REPORT.

Ellen stated that at the last Council meeting (8/14) Jimmie had made a presentation pertaining to the history of the Roles and Responsibilities Task Force. He discussed how it was formed, their intentions, and the context of the development of the document. Ellen indicated that she would be presenting on behalf of Lyn pertaining to the actual contents of the document and the Council's relationship to the document. She summarized that before 1994, the CDC funded the DPH as the grantee, with no community involvement mandated. In 1994 the CDC determined that they needed the community involvement, hence they initiated HIV Community Prevention Planning. The primary relationship remains between the CDC and the DPH; but now, HPPC involvement is outlined and mandated.

Ellen indicated that last year the HPPC and the AO had many questions and discussions about who was responsible for the specific aspects of their collaboration. The Roles and Responsibilities document was a first attempt at describing each of the roles of the partners, their responsibilities, and their purview. She referred to a diagram that summarized what the document reflects.



Ellen stated that the diagram depicts that the AO is solely responsible for certain aspects, as is the HPPC. In addition, both the AO and the HPPC have some shared responsibilities. The document also includes descriptions as to the manner in which the partners of this collaboration should relate to one another. She noted that the Task Force used the CDC Guidance, DPH Protocol, and HPPC By-laws to develop the document.

She noted that at the last meeting Mitch Katz had yet given his approval of the document, but has done so since then. Ellen stated that this is only the first phase of discussions the Council will conduct pertaining to this document. Understandably, the Task Force members spent an entire year working on it; now the Council needs to begin digesting it. Jimmie expressed his confidence in the document. He reiterated that its development was a result of a yearlong DPH/AO and HPPC collaboration.

Ellen stated that the information in the document could be categorized into two distinct groups: 1) Process -- that is open for discussion and modifications. 2) Descriptions of Roles -- that again is open for discussion, but not open for modifications. The types of things that can not be revised include the CDC Guidance information and the DPH protocol information. She noted each of the document sections -- A through L -- with the corresponding designation, process or description.

Section A:	*Membership*	➢	*Process*
Section B:	*Governance of Council*	➢	*Process*
Section C:	*Meetings -- Council and Committee*	➢	*Process*
Section D:	*Planning Activities*	➢	*Description*
Section E:	*Implementation of Priorities and Recommendations*	➢	*Description*
Section F:	*Other Implementation Activities*	➢	*Process & Description*
Section G:	*Administer and Coordinate Funds*	➢	*Description*
Section H:	*CDC Cooperative Agreement Application*	➢	*Description*
Section I:	*Communication*	➢	*Process*
Section J:	*Mutual Accountability*	➢	*Process*
Section K:	*Conflict Resolution*	➢	*Process*
Section L:	*Grievance Procedures*	➢	*Process*

HPPC RESPONSE TO ROLES AND RESPONSIBILITIES DOCUMENT

In response to a member's question, Ellen clarified that the entire document is open for any and all discussions. However, there are certain aspects included in the descriptions of roles, that can not be modified or revised by the Council.

Maria referred to the fourth paragraph of the introduction. She noted the use of the word 'advisory' in this paragraph as well as in several other places throughout the document. She requested clarification on the definition of this word since it was unclear why the Council was advisory in some aspects and then binding in others. Ellen responded that this request for clarification had been the key motivation behind developing this document. She explained that the Council has sole responsibility for developing prevention priorities -- per the CDC Guidance. The implementation and funding allocation of priorities is the sole responsibility of the DPH. However, the DPH must consider HPPC feedback, when making the implementation decisions. Ellen indicated that the Task Force spent a considerable amount of time developing Section I - Communication, in order to assure the smooth and effective process of feedback between the DPH and HPPC. She added that the role of the HPPC is multi-faceted, it is both Advisory and Binding.

Jimmie reiterated what he stated at the last meeting as being a key to understanding the role of the HPPC: ***'...the HPPC has final authority over the establishment of HIV prevention priorities. The DPH has authority over the implementation of these priorities; as an advisory body, the HPPC makes recommendations to the DPH.'*** He stated that since the creation of this document, the HPPC and the Council have established a valuable link that was not there in the past. The communication piece is imperative to avoid experiencing a situation where a partner of the collaboration is unaware of what the other partner is doing.

Elizabeth referred to *Section J, Mutual Accountability, Responsibilities of the DPH/AO Staff* -- Number Two. She requested that language be added to reflect that the DPH/AO staff also "listen to and respect prevention providers in the community." She also requested that another number be added to this section stating the Responsibility of the DPH/AO staff to the community at large. Chata expressed his agreement that the recommendations be added to the document. He indicated that this was an important issue for all members involved. The HPPC and the community at large would also need to reciprocate that respect to the staff of the DPH/AO, particularly when discussing and negotiating controversial issues.

Maria referred to *Section C, Meetings - Council and Committee.* The last sentence of the italicized introduction paragraph noted that: "...Council members have a role in deciding how much and what type of support the HPPC needs..." Maria asked for clarification as to whether the Council had exclusive responsibility or if they were part of a collaborative effort to determine the HPPC needs. Chata responded that the first paragraph of this section addresses that specific question, by indicating that it was indeed a collaborative effort.

Steven stated that he would like to see the technical support staff review this document once more to clarify the language a bit more for the sake of future Councils. Ellen suggested that any language modifications or revisions be forwarded to Lyn and the technical support staff.

Maria asked for clarification as to what the Council can modify or not modify in this document. She is interested in knowing what parts of the document are specific to the CDC Guidance, which are specific to the HPPC By-laws, etc. She would also like to know where the decisions come from if they do not come from the CDC Guidance or the HPPC By-laws. Chata stated that the Task Force worked to reach agreement with the DPH as far as the amount of inclusivity the HPPC could have pertaining to the implementation and allocation of funds. He reiterated that this is not a negotiable section since it is stipulated in the CDC guidance that this is the sole responsibility of the DPH. However, he reminded the Council that this document is a work in progress, that is by no means set in stone. It is the beginning of a structure that will facilitate the negotiations between the DPH and the HPPC in the future.

Ellen indicated that the definitions and roles are an expansion of the CDC Guidance language. She noted that in some states and cities departments of public health do not allow the community planning councils more than what is stipulated in the CDC Guidance. She added that the HPPC is fortunate that San Francisco DPH is welcoming and soliciting feedback from the Council. However, she reiterated that the CDC and their Guidance have and are the documents which outline the minimum roles of both Councils and DPHs.

John Blake West noted that it would be frustrating to attempt to revise any document without knowing what all of the problems are. He suggested that the Task Force establish a process to solicit, receive and incorporate the specific input from the Council to allow for a more logical and less iterative procedure. He indicated that there were a few things in the document that could use some clarification, but overall he felt comfortable with the document.

Tracey agreed with John and added that the Task Force welcomed any and all questions, comments and feedback the Council was willing to provide on any section of the document. She stated that everyone on the Council should have the same understanding of the document and the decisions that were made as the members of the Task Force.

Steven referred to *Section L, Grievance Procedures, Number Four*. He asked for clarification as to who would determine the selection of the professional mediation service. He suggested that clearer and more specific language be included pertaining to the selection of the mediation services. Ellen noted that the Task Force had discussed utilizing a mediation service that offered the services for free, but agreed that there was a need to further clarify this section.

Maria thanked the Task Force for its efforts. However, she indicated her discomfort with the current process. She stated that she would like to see the Council vote on the document, instead of being told that the decisions have all been made without the full Council's input.

Ellen stated that due to the sentiment that Maria had expressed at the last meeting -- the Co-Chairs had re-visited the idea of putting the document to a vote. The Co-Chairs had reviewed the document and looked for the specific areas that the Council could change or modify, hence they came up with the Process versus Definitions groupings. She explained that their intent had not been to complete the task of reviewing the document in one phase, but rather in two, perhaps three phases. She recommended that the Council members submit any language changes, comments and revision to Lyn prior to 9/17 in an attempt to address the issues at the 9/25 Council meeting. On behalf of the Task Force she extended their appreciation to the Council for their patience and support.

4. SUPPLEMENTAL FUNDING UPDATE

Ellen introduced Valerie and commented that the Roles and Responsibilities Document had been instrumental in the process utilized for the supplemental funding. Valerie agreed that this supplemental funding was a perfect example of the DPH/AO and HPPC working together through clarified roles and responsibilities. The HPCC, primarily the SFTF, came up with the priorities and then provided the DPH/AO with input and recommendations. The AO then utilized that information to make their decisions about implementation.

Valerie reiterated that the DPH/AO took all of the information from the Supplemental Funding Task Force (SFTF) and the HPPC to develop their implementation plan for the supplemental funding. The Principles they followed included several premises. The first premise was one of inclusivity. The AO staff looked at all of the current prevention contracts, as well as proposals to RFPs 015 and 016. They sorted them into natural groupings that addressed the seven behavioral risk populations identified by the SFTF and approved by members at the July 10 Council meeting. The AO staff then determined the specific amounts for each of the populations naturally grouped.

Valerie explained that the AO decided to use the 1998 supplemental funding dollars for an RFP that would address speed users, the number one priority. The reasoning behind this decision was that through research, the AO was unable to find many agencies within the existing contracts and proposals that specifically targeted speed users. Knowing that there is information about speed use, harm reduction, and treatment on demand available for this population, the AO decided that they would open up the field to additional providers, with the intent being that they will recruit agencies that have or are gaining the experience with this population. Valerie indicated that some of the supplemental funding had also been earmarked for media. However, since there were unobligated funds for media that needed to be spent by the end of December, the AO could work with agencies to re-issue and update existing media, rather than start a new campaign from scratch.

Valerie then distributed a handout that listed the five priority populations by the natural groupings identified by the AO. Each priority population listed included: The specific population description, as determined by the HPPC, the amount of funding available, the agencies that submitted applications and

the agencies invited that had not submitted applications. The following table depicts the priority populations as grouped by the AO. It lists the corresponding HPPC identified population and the amount of funding available for each.

Priority Populations as Grouped by the AO	HPPC Identified	Funding Available
1) Queer Youth: MSM, MSM/F - Youth (<24), all ethnicities, men of color (specifically African American, Native Americans & Latino Youth 18-24).	Population # 2	$200,000
2) Injection Drug Users: MSM-IDU, MSM/F-IDU, MSF/IDU - Male injection drug users (includes bisexually acting and African American) & FSM/F-IDU, FSM-IDU - Women who inject.	Populations # 3 & 8	$100,000
3) MSM/F, MSM. MSF - Latino immigrant and migrant, indigent population with other co-factors such as drug or alcohol use and poverty.	Population # 7	$125,000 (Populations 4 and 7 combined.)
4) MSM. MSM/F - Specifically targets Native American and African Americans.	Population # 4	
5) Both Populations: (a) MSM/F, MSM, MSF - Latino immigrants and migrant, indigent population with other co-factors such as drug or alcohol use and poverty. (b) MSM. MSM/F - Specifically targets Native Americans and African Americans.	Populations # 4 & 7	

Valerie summarized that the AO had sent out invitations to approximately 31 agencies. Some of the agencies received invitation letters for more than one of the priority populations. The agencies were required to respond by noon on 9/9. Although the AO received 21 applications, the vast majority of them were lacking pertinent information about the populations they would be targeting. The AO has sent out letters to the agencies requesting clarification and feedback from the agencies by noon on 9/17. The AO had requested that agencies agree to fulfill several requirements based on the HPPC recommendations. Most of the agencies said that they would, some said they would not and some did not respond. Customarily, when agencies choose to not comply or respond, they are eliminated from the process. However, the AO decided to provide all agencies with a second opportunity to comply with the standards set based on the HPPC recommendations.

Valerie noted that the AO had received a very broad range of applications. However, the AO had anticipated a larger response rate. She pointed out that because there were fewer applicants some of the agencies might be eligible for additional funding.

HPPC RESPONSE TO SUPPLEMENTAL FUNDING UPDATE

Chata expressed his concern that there seemed to be only one Native American agency, and they had chosen not to apply. He stated that this is a notable concern if the HPPC specifies priorities and no one chooses to represent them. He asked for clarification as to what recourse the AO will utilize in this situation.

Valerie noted that there were several options that the AO could utilize. The AO could augment an existing contract that is already working with the specific population or sole source. However, sole sourcing would be a somewhat tenuous option because of DPH policies. The last option could be to reserve some of the 1998 supplemental funding for an RFP that would address the specific gap.

Elizabeth commended the AO staff on their innovative approach -- allowing the applicants a second opportunity to respond.

Maria asked for clarification as to whether the AO or the SFTF had determined to group the HPPC identified populations #4 and #7. Valerie reiterated that the grouping of those populations had been the decision of the AO, in an attempt to group similar populations. Maria expressed agreement with Elizabeth's commendation of the AO. However, she stated that if an agency chooses not to comply with an application, it is her belief that they should be eliminated. Lastly, Maria thanked the AO for their implementation of the HPPC recommendations.

Valerie indicated that this had been a difficult but effective process. It had offered an opportunity for the AO to use a new way of doing things. She thanked the HPPC for all of their hard work.

Kathleen asked for clarification pertaining to the possibility of the HPPC expecting to participate in a similar process -- with supplemental funding more regularly. Valerie stated that this process could be used with supplemental funds which is likely to occur every other year, but the process is less inclusive when an RFP process is used, as with non-supplemental funds. Kathleen stated that the Process Evaluation Team could follow-up on the outcomes of the process, by contacting the agencies involved. The feedback and input could be helpful in determining if the process was something the community of service providers liked, did not like, etc. Valerie agreed that it would be indeed helpful. Council members expressed their agreement. Kathleen stated that once the process was completed, the Process Evaluation Team would begin to contact the agencies.

Brian responded to a member's question pertaining to the list of agencies depicted in the CDC Cooperative Agreement Application, pages 44-45. He stated that it was a complete list of prevention providers that had been sent the invitation to apply for the supplemental funding.

Tracey asked if there were any other questions or comments. There were none. Tracey indicated that the AO would keep members informed of the process and would report on the outcomes at the 9/25 Council meeting. Tracey then indicated that members should complete the evaluation on the Supplemental Funding Update Presentation.

5. BREAK

6. CDC COOPERATIVE AGREEMENT APPLICATION PRESENTATION & VOTE.
First, Valerie clarified that the AO was only re-sending letters to those agencies that had initially applied. All other agencies were no longer eligible. Secondly, she stated that the AO had recently received a letter of award for the first series of unobligated funds -- to fund the Young Women's Survey and the Detuned Assays. She indicated that due to some administrative changes within the CDC grants management office, it had taken longer than usual. She noted that the a letter of award for the second series of funding -- $166,000 -- should be arriving soon.

Tracey thanked Valerie, and then introduced Brian for his presentation on the CDC Cooperative Agreement Application. She indicated that members had received a draft of the application for 1998 previous to the meeting and asked that members refer to that during the presentation.

Brian gave a brief summary of his last presentation from August 14 Council meeting pertaining to the application. He reiterated that the CDC Cooperative Agreement Application is a non-competitive annual

process that provides funding for the AO to contract out to prevention providers of San Francisco. He indicated that the application is due to CDC on October 3rd, and will ideally be mailed out on September 26. Brian informed the Council that there were three specific areas in the Draft that needed to be reviewed and if necessary discussed. 1) The 1998 Community Planning Objectives on page 14. 2) The Short and Long Term Goals and Measurable Objectives for HIV Prevention Activities in Defined Populations on page 22. 3) The Programmatic Objectives and Activities for 1998 on page 40. He explained that the Council will discuss the contents of the application and then vote on a letter of concurrence stating that the priorities listed in the application match the priorities of the Plan.

Brian stated that the Programmatic Objectives and Activities on page 14 are a requirement of the agreement. The section includes:

a) Counseling, Testing, Referral and Partner Notification (CTRPN),
b) Health Education/Risk Reduction (HE/RR),
c) Public Information,
d) HIV Prevention Capacity Building Activities, and
e) Other Activities

Brian indicated that there were some '97 objectives -- as seen on page 4 and 5 of the application -- that had not yet been incorporated into the '98 objectives. These will be updated and then incorporated into the 1998 objectives before the application is sent. In response to a request for clarification, Brian stated that the timeline for the objectives would essentially be the same, unless there should be objectives that will be completed sooner. If that is the case, the timeline will reflect that. Equally, some of the objectives may not be completed in '98, and they will be listed as such. John West noted his concern that it might be damaging for the AO to list objectives that were not achievable. Brian responded that the AO would not be penalized for uncompleted objectives. We would report on the progress of these objectives, even if they are not completed. Valerie added that another possibility that has occurred in the past, is that the CDC states that the AO must complete as much as possible of the given objective this year or in the coming year.

Brian asked Council members for additional comments, questions and/or input.

HPPC DISCUSSION PERTAINING THE CDC COOPERATIVE AGREEMENT APPLICATION
Chata inquired about the location of the planning support contract in the application. Brian responded that it had not been listed in this draft. However, it would be picked-up from the progress report and carried over to the Community Planning Objectives for 1998. Chata requested access to review the application once this had been added. His intent was to avoid experiencing a similar situation as earlier this year pertaining to the planning support contract. Brian noted that there was a line item in the draft budget for the technical support contract. (Draft budget distributed at this time.)

Valerie pointed out that the budget item that Chata was referring to could be found in the Contractual Services row, in the Capacity Building column -- a total of $350,000. This amount includes: $250,000 for the Council planning support and $100,000 for the organizational development technical assistance (OD/TA) support. (Currently with the Support Center.) She added that there will be additional support that will be on the DPH side of the budget. She reiterated that the line item of $350,000 reflected the OD/TA support to this Council and to the CBOs.

In response to a request for clarification, Brian explained that the 1997 Goals and Objectives that will be carried over into 1998 will be reviewed by the Steering Committee. The Steering Committee will then

determine if there is a need for any modifications. The AO will submit those HPPC approved Goals and Objectives to the CDC sometime in December 1998.

Steven expressed his concern that some of the goals and objectives -- listed as 'progress' or to be completed later, are very pertinent to the Council. He stated that his particular concern has to do with the PIR related goals and objectives. Brian stated that this is an ongoing activity, since the CDC seeks a representative body. The AO and the HPPC Membership Committee are committed to that. Recent recruitment efforts have specifically targeted African Americans, Youth, HIV Positive, Non-CBO Affiliated individuals, and etc. (*Brian added that if any HPPC member knew of an African American minister interested in participating on the Council, they should please forward his name to the Membership Committee or the AO.*)

Maria referred to page 48 of the application. She noted that the table that indicates the currently funded agencies was a bit misleading in its duplication of the total agency award. She recommended that the amount of funding be listed by interventions. Valerie expressed her agreement and stated that this would be revised to reflect the actual amounts.

Ellen noted that she would forward her comments and recommendations which were mostly in structure , not content, to Brian later. However, she wanted to point out a specific point of clarification that needed to be addressed. Beginning on page 20 of the application, the language states that the work of the SFTF was to be used for the Council's overall prioritization process. She indicated that it should describe the work of the Task Force as being the priority setting for a specific pool of supplemental funding. She noted that this problem in the language of the application occurred in several places of the application.

Brian thanked everyone for their feedback. He pointed out that he had revised page 20 to reflect Ellen's comment. He requested that Ellen and other members that had comments, word clarifications, etc., forward the information to him as soon as possible. ***(Fax: 431-7547 & Direct line: 554-9499.)***

Ellen noted that this vote on the CDC Cooperative Agreement Application is one of the most important tasks that the Council will perform. Being that this about $8.1 million, this vote is significant. The vote will reflect the Council support of this application for funding. It indicates that the Council supports the goals and objectives as listed for the next year. She urged members to take this opportunity to indicate any issues, concerns and/or revisions to the application.

Brian responded to a question about the correspondence of the Plan priorities and the application priorities. He explained that the application priorities were based on the 1997 version of the Plan. If the Plan priorities should change, then the application priorities must also change to reflect those changes.

John Newmeyer asked for clarification about the Full Time Employees (FTEs) line items. Valerie responded that it is partly representative of the contracts within the DPH programs; some FTE costs are less than others. John summarized that we are fighting 500 sero-conversion per year with an army of 120 FTE. He added that this seemed like a great bargain.

Steven referred to page 16, Objective #3. He recommended adding the language '*sexual orientation*' to the first sentence. Brian agreed to add the language.

Tracey then asked if there were any additional questions, discussions or comments. There were none. She then described the meaning of letter of concurrence and a letter of non-concurrence.

Letters of Concurrence: Letters of concurrence or non-concurrence must indicate the extent to which the grantee and the HIV Prevention Planning Council have successfully collaborated in developing a comprehensive HIV Prevention Community Plan, and agree upon program priorities contained in the application.

Letters of Non-Concurrence: Letters of non-concurrence must cite specific reasons for the non-concurrence. In situations where the community planning group does not concur with the program priorities identified in the application, and the grantee is proposing to implement activities or allocate resources based on other priorities, a letter of justification from the grantee must accompany the application.

John Newmeyer made a motion for a letter of concurrence for the CDC Cooperative Agreement Application, with the above mentioned revisions. John Blake West seconded the motion. Tracey facilitated the vote. At this time Ellen notified the Council that Sacul and Askia had requested that she indicate each of their votes for a letter of concurrence. (While the votes could not technically be counted in their absence, it is important to ensure their voices were heard.) With a quorum of 20 voting members present, the motion carried unanimously.

Chata expressed his satisfaction with the process and outcome of the CDC application vote. He stated that this Council and the DPH have undergone a positive transformation. The Council has moved from advocacy to planning while the relationship between the DPH and the Council has been clearly defined through the Roles and Responsibilities Document. He commended everyone for their hard work and positive progress.

7. CLOSURE/EVALUATION

Tracey thanked everyone and asked that members complete their evaluation forms before leaving.

Attached to these minutes for absent members:

- "Memorial for Kurt Weeks"
- LIFE: California's Lesbian/Gay & AIDS Lobby & Institute flyer
- The Susan G. Komen Breast Cancer Foundation, Race for the Cure flyer,
- The Castro Lion Newsletter,
- Castro Lions "Entertainment '98 Books" flyer,
- "Process Evaluation Results" and "Participant Dialogue" box from the August 14, meeting.
- MidCity Number, a Monthly Bulletin of AIDS Related Statistics, July '97
- 1997 Cooperative Agreement Supplemental Funds Handout,
- 1998 CDC Prevention Grants Draft

Minutes Recorded by: Amalia Fernandez-Niewendorp, Polaris R & D, Inc.
Minutes Approved by: Ellen Goldstein, Co-Chair and Tracey Packer, DPH Co-Chair

AGENDA

HIV PREVENTION PLANNING COUNCIL MEETING

September 25, 1997
3:00 PM to 5:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

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Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer

Please read: **Agenda, Minutes from August 14, OD/TA 1997: 6 Month Report**
Please bring: **Agenda, Minutes from August 14, OD/TA 1997: 6 Month Report**

Agenda

NOTE: MEETING WILL START PROMPTLY AT 3:00 P.M.

1. Food/Welcome/Introductions/Announcements	Chata	3:00 - 3:10 PM
2. Review and Approval of 8/14 Minutes	Tracey Packer	3:10 - 3:15 PM
3. Membership Committee Update	Jelousy Jiggetts	3:15 - 3:30 PM
4. Presentation: Organization Development/Technical Assistance	Organizational Development/ Technical Assistance Team & Prevention Providers	3:30 - 4:55 PM
5. Closure/Evaluation	Chata	4:55 - 5:00 PM

Upcoming Meetings

HPPC Meeting - Thursday, October 9, 1997, 3-6 PM, First Unitarian Church 1187 Franklin Street (@ Geary)
HPPC Meeting - Thursday, October 23, 1997, 3-5 PM, First Unitarian Church 1187 Franklin Street (@ Geary)

HIV PREVENTION PLANNING COUNCIL

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September 18, 1997

Dear HIV Prevention Planning Council (HPPC) Member,

At the September 25th HPPC meeting there will be a presentation on the Organization Development/ Evaluation Technical Assistance Project (OD/TA). This project is part of the Strategic Evaluation Plan developed by the Council and included in the 1997 HIV Prevention Plan. Through the OD/TA Project, technical assistance is made available to all AIDS Office funded prevention providers with the goals of strengthening organizational capacity and enhancing capacity to conduct program evaluation within our prevention provider community.

Attached please find a copy of the six month progress report of the project for your review. If you would like more information on this project, please refer to Chapter 9 of the Plan, pages 606-612, and Chapter 10, pages 657-661.

There will be a short presentation by those involved in the project and there will be plenty of time for the HPPC to discuss the project.

See you on the 25th,

Tracey Packer
DPH Co-Chair

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OD/TA 1997: 6 Month Report

Overview

This report provides information on the progress toward completing the goals and objectives of a contract between the San Francisco AIDS Office and the Support Center for Nonprofit Management in the amount of $116, 165.

The report is divided into four sections:

1. Purpose of the project
2. Progress toward completion of 1997 project objectives
3. What we have learned so far
4. Implications for the project

Purpose of the project

> *The people who are at risk for HIV today are those for whom behavior change is extremely difficult, new arrivals to the City who have not been exposed to comprehensive prevention interventions, youth who are just starting sexual and drug experiences, and people who need continual support for safe behavior.*
>
> SAN FRANCISCO HIV PREVENTION PLAN 1997, PG 685

As the conclusion to the HIV Prevention Plan above notes, HIV prevention work is now focussed on people "for whom behavior change is extremely difficult." This situation makes it difficult to do prevention work, yet more important than ever to measure the effectiveness of such work.

From the contract statement of need:

> The HIV Prevention Planning Council recognized in its first year of planning that without a reliable system of evaluating the effectiveness of different intervention strategies in various settings, meaningful decision making about priority interventions could not take place.
>
> The purpose of this project is to address the need for capacity building and organization development among community based organizations, Department of Public Health Programs and the AIDS Office in order to increase the effectiveness of HIV prevention efforts in the city.

The Organization Development and Technical Assistance Project (OD/TA) was begun in 1996 with a comprehensive assessment of the organizational capacities of prevention programs in the city. In 1997, year two of the project, the focus is on delivering capacity building services to prevention programs. A specific focus across all programs is the requirement to conduct a Behavioral Risk Assessment for the target population(s) worked with by prevention contractors.

Progress toward completion of 1997 project objectives

There are nine objectives for the project in 1997, discussed as tasks in the contract narrative. Progress with respect to each is noted.

Task 1: Meet with AIDS Office on a regularly scheduled basis.

- The Support Center Project Director held four meetings with staff from the AIDS Office in December and January to refine implementation plans for the project.

- Beginning in January, two AIDS Office staff members have regularly attended meetings of the Consulting Team.

- A "community meeting" was held in January to provide information about the project to participating prevention programs. 17 of the 27 programs currently participating attended. All others received the information. Seven AIDS Office Program Managers with responsibility for prevention contracts attended this meeting.

- Regular phone contact has been maintained with the responsible AIDS Office Program Manager.

Task 2: Convene a Consulting Team, and hold regular meetings of the Team, which will collectively deliver the technical assistance to all providers. At the regular meetings of the Consulting Team the contractor will attend to issues of consistency, quality assurance, trouble-shooting, and will adjust the overall plan as necessary. The AIDS Office will participate as frequently as possible in these regular meetings.

A Consulting Team with ten members was assembled in January to deliver the technical assistance to all providers. The team is organized into 5 site teams each comprised of one OD specialist and one evaluation specialist.

The plan to organize the site teams evolved from much discussion with both members of the HPPC Evaluation and Technical Assistance Committee and with various members of the AIDS Office. Originally the thought had been to have a single "case manager" contact consultant who would then serve as a broker for other assistance. The overall emphasis on evaluation in the HIV Prevention Plan led us to choose the team of consultants instead. One benefit of this approach is that we have two individuals helping with the overall assessment of needs. Another benefit is that the team is better positioned to manage the interplay between evaluation capacity building needs and other organization development needs at individual agencies.

The team was recruited from five consulting/training organizations including the Support Center (3), Polaris Research and Development (2), Harder+Co (1), Communication Sciences Group (1), STD/HIV Prevention Training Center (2) with one additional evaluation specialist from the AIDS Office (1). The team represents both professional and demographic diversity with six Caucasians and four people of color, six gay/lesbian members and four heterosexual, six women and four men.

The entire Consulting Team has met four times since January. In addition, the OD specialists have met as a group two times and the Evaluation specialists have met as a group three times. Additional coordination has been provided through four meetings between the OD group leader and the Evaluation group leader.

A significant amount of attention has been paid to issues of quality assurance and trouble-shooting. The results of these discussions are presented below in the section below: "What we have learned."

Task 3: Develop written Capacity Building Plans for each of the participating CBO and DPH prevention programs.

A total of 23 community-based organizations are participating in this project. Of the 7 DPH prevention programs identified as eligible by the AIDS Office for assistance through this project, 4 are currently being served, 2 have declined to participate and 1 has not yet decided whether or not to participate. Thus, 27 prevention programs are currently participating.

As of June 30, 1997, contact had been made with all 27 programs. Because over half of the programs have contracts with the AIDS Office beginning in July, and because several of the other programs did not finalize their contract negotiations until at least April, the development of capacity building plans is expected to be

completed in early September. Nonetheless, most programs have been able to utilize short-term technical assistance during this start-up phase

Task 4: Develop a Resource Pool from which technical assistance resources may be utilized in the service of fulfilling the Capacity Building Plans.

A resource directory has been assembled and is continually being refined as new needs emerge from the programs, and as new resources are investigated.

Task 5: Deliver capacity building technical assistance in accordance with Capacity Building Plans to approximately 25 CBOs.

Although the capacity building plans have not been completed, capacity building technical assistance has been delivered (organization development and/or evaluation) to all but 3 of the programs by June 30. (It is important to note that it has been much easier for programs to identify immediate needs--hence the immediate delivery of technical assistance--than it has been to identify long-term capacity building needs). This assistance ranges from facilitation of board retreats, to attendance at various classes to individual assistance in developing the BRA. (See attached report to the HPPC Evaluation and Technical Assistance Committee for details on assistance delivered to each program.)

Task 6: Deliver capacity building technical assistance in accordance with Capacity Building Plans to approximately 7 DPH programs.

All programs have been repeatedly contacted. All 4 of the 4 participating DPH prevention programs had availed themselves of technical assistance by June 30. As mentioned earlier, two have decided not to participate and one has yet to decide whether or not to participate. One difficulty here has been that only one of the DPH programs put money in their budget for additional evaluation efforts required in 1997. (See attached report to the HPPC Evaluation and Technical Assistance Committee for details on assistance delivered to each program.)

Task 7: Deliver capacity building technical assistance to assist CBOs required to conduct a Behavioral Risk Assessment in successfully meeting this requirement.

A comprehensive support system has been developed to assist CBOs with the BRA requirement. In addition to the assignment of an evaluation specialist to each agency, the evaluation specialists meet as a group and assist one another when appropriate to support individual agencies. In addition, the consultants are investigating various software applications in order to assist agencies that need to develop data processing capacity to choose new applications wisely.

Task 8: Investigate alternative resource possibilities (in addition to agency-centered technical assistance) which could support the ongoing, comprehensive HIV prevention effort.

Discussion at the Consulting Team meetings has begun to explore this topic. Initial ideas include a centralized "clearinghouse" for disseminating new research findings to all prevention programs, developing a data processing resource to support smaller agencies, convening programs using similar interventions to discuss joint learning and innovation, holding a conference to bring national resources to San Francisco. While the focus for 1997 is on basic capacity building assistance, the discussion about developing alternative resources is appropriate to begin in earnest this year. The discussion is still at the idea-generating stage.

Task 9: Conduct assessment with the AIDS Office prevention-oriented units; develop report summarizing needed capacity building.

Staff changes at the AIDS Office and other related delays have postponed the initiation of this task.

What we have learned so far

1. The project is well designed and on target in supporting the goals of the HIV Prevention Plan. The response from most programs we have begun work with is enthusiastic and there are numerous opportunities for providing assistance in capacity building.
   - ❑ The HIV Prevention Plan outlines a bold change for all prevention contractors in San Francisco toward an explicit focus on evaluation and learning about effectiveness. We have come to understand that this change is in reality a "culture change" in the delivery of prevention programs in the City. Contractors are aware of the magnitude of the change required and welcome the comprehensive support provided by the AIDS Office and Planning Council through this project.

- ❑ As a result of this project, the Consulting Team is confident that nearly all of the prevention contractors will conduct an acceptable Behavioral Risk Assessment in this, the first year of the requirement. Based on the work the Consulting Team has done already, we are confident that the quality of the BRAs will be significantly higher than they would have been without the intensive one-on-one assistance.
- ❑ The collaboration of several consulting and training organizations with the AIDS Office in the design and delivery of this project has allowed a very wide range of expertise to be available in an accessible, client-centered consulting design to prevention contractors. The opportunities for cross-learning, and for bringing to bear awareness of and access to a multitude of resources makes it clear that the Consulting Team as a whole is much richer than a simple sum of its parts. Consulting Team members are enthusiastic about both the design of the project and the potential impact of this project.

2. Nonetheless, the scale and scope of this project have surfaced a number of unexpected complexities. The consulting team has identified a few key points.
   - ❑ It takes time to develop a consultant-client relationship. The services being offered involve important and often sensitive issues. While every effort has been made to offer client-centered consulting services, the relationship still requires a "getting to know you" period. Efforts to accelerate the process are therefore, naturally, resisted.
   - ❑ At organizations where prevention is a small part of the agency's overall work, this project is sometimes given lower priority.
   - ❑ Groups without staff who have been actively involved in the HIV Prevention Planning process are less "ready" to begin with the work of the Behavioral Risk Assessment and other capacity building efforts. The benefit from participating in the planning process does not necessarily "carry over" to other staff at a given agency. Thus, it is only where the individuals currently responsible for prevention work have been involved that consultants have experienced this additional readiness.
   - ❑ The relationship contractors have with the AIDS Office continues to contain ambivalence and some tension. In a few cases, programs have seemed to look on the OD/TA project as "one more thing" required by the AIDS Office rather than as an offer of support.
   - ❑ The lack of understanding about the types of assistance included under the "organization development" umbrella has required consultants to spend a significant amount of time educating the prevention programs about their options. On the other hand, the type of assistance available to support program evaluation efforts is relatively well understood.

3. Many programs are not clear about their capacity building needs. This is surprising given the extensive assessment process conducted during 1996. Because of staff turnover, changes in the program's situation in a year, and other reasons, the assessment reports have proven more useful as background information for the consultants than they have as "draft capacity building plans." The information collected during the assessment process was essential in designing the current capacity building services, and in developing a baseline understanding of program organizational and evaluation capacity, and will be most useful in looking at the development of the capacity of the community based prevention network.

4. Several factors have required changes in the project timeline.
   - ❑ Given the fact that more than 50% of the programs have contracts that did not begin until July it was unrealistic to expect many of these programs to begin work on capacity building before the work of the program contract began. While there was an opportunity for these groups to "get ahead of the game" by developing a capacity building plan and designing their Behavioral Risk Assessment, this was only done by two programs. Staff at two other programs did not even want to meet with the consultants until their contracts began! Prior to the beginning of the OD/TA project the project contractor did not know this fact.
   - ❑ Staff turnover has caused significant delays in working with several programs. A few organizations have hired new Executive Directors, Program Directors and other staff during the first six months of 1997. A few organizations will not have fully staffed prevention programs until August or September of this year.
   - ❑ It is not uncommon for prevention programs to be in a crisis mode of operations. This has the result for some program staff of lowering the priority of a proactive, longer-term purpose (designing and receiving technical assistance.) We have had difficulty getting return phone calls from some organizations, let alone getting sufficient attention from them to commence the project in a meaningful way at those sites.

5. A number of common themes characterize situations where the consulting relationship is working well:
   - ❑ Spending lots of time with program staff. In some cases, consultants have met three or four times to discuss various program needs, the various types of support available through the project and to identify priorities. In the course of these discussions, clarity about capacity building needs is achieved as is a comfortable working relationship.
   - ❑ Organizations that are experienced with using consultants and other types of "outside assistance" are able to more quickly develop a productive relationship with our consultant teams.

- Programs where key staff has been involved with the development of the Prevention Plan are more likely to be "ready to go."
- Setting discrete, measurable objectives for the capacity building services, rather than trying to quickly to develop comprehensive, long-term capacity building plans, has allowed consultants to begin adding value immediately.
- Organizations which have done a significant amount of internal planning typically have developed an internal consensus about their strengths and weaknesses and are consequently able to articulate capacity building needs.
- Finally, the Consulting Team has developed a metaphor regarding utilization of technical assistance. The programs seem to have certain characteristics in common with their clients: that is, in cases where there is a clear and urgent need for assistance, programs have been quite willing and able to make use of assistance—this is analogous to a patient seeking "primary care" health services. On the other hand, in cases where the work is more like "prevention" health services, there has sometimes been reluctance on the part of programs to invest in proactive measures.

Implications for the project

The overall plan for the project remains remarkably robust for an effort designed to reach all prevention providers in the same time period. The fine-tuning which the Consulting Team, in consultation with the AIDS Office Program Manager, has decided upon includes the following points.

1. The capacity building plans will focus on the first year, rather than on developing 3-year capacity building goals. Program staff simply is not prepared to articulate longer-term goals at this point.
2. Programs with contracts beginning in July will be given twelve months to develop the capacity building plan and to utilize the services of their consulting team.
3. The Consulting Team will place its energy and emphasis on groups that are ready and able to accept help. There is a significant "timing" issue to making good use of outside assistance. Assistance will continue to be offered equally to all contracted providers but will be delivered in accordance with need and ability to utilize the resource.
4. Programs which have not chosen to participate to date will be contacted quarterly to check-in and continue to make available the services should the circumstances of the program change.

Attachments

Attached are a table listing all prevention programs involved with the OD/TA project and the June report to the Evaluation Technical Assistance Committee of the HIV Prevention Planning Council.

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HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for September 25, 1997

* Please note in your calendar any of the following meeting times that apply to you: *

HPPC:	Thurs., Oct. 9, 3-6 p.m. at the First Unitarian Church
	Thurs., Oct. 23, 3-5 p.m. at the First Unitarian Church
Linkages Committee:	Mon., Oct. 6, 3-5 p.m. at the AIDS Office
	Mon., Oct. 20, 3-5 p.m. at the AIDS Office
Assessment Committee:	Fri., Oct. 3, 10-12 p.m. at the AIDS Office
	Tu., Oct. 7, 1-3 p.m. at the AIDS Office
Evaluation Committee:	Tu., Oct. 7, 5-7.m. at the AIDS Office

Members Present:
Barbara Adler
Ronnie (Chata) Ashley
Marcos Bañales
Michael Discepola
Brenda Escobar
Ellen Goldstein
Jelousy Jiggetts
Valerie Kegebein
Sacul L'Adnbre
Sonja Mackenzie
Askia Muhammad
Jimmie Naritomi
Henry Ocampo
Tracey Packer
Colin Partridge
María Rinaldi
John Blake West

Members Absent:
Elizabeth Davis
Kevin Gogin
Liz Highleyman
John Newmeyer
Dawn Passar
James Rapues
Joel Reyna
Steven Sams
Sandy Simms
Thomas Zickgraf

Leave of Absence
Jennifer Lorvick
Bethsaida Ruiz

AIDS Office Staff:
Brian Dobrow
Marshia Herring
Mike Pendo

Guests:
Mike Allison, Support Center
Tamara Ching, Southeast Asian Community Ctr.
Natalie Gutierez, WFCHP
Ron Strolich, Support Center
Stacy Vogan, STD/HIV Prevention Training Ctr.
Joshua Volle, STD/HIV Prevention Training Ctr.

Harder + Co./Polaris, Inc.:
Amalia Fernandez-Niewendorp, Polaris, Inc.
Rick Green, Harder + Co.
Lyn Paleo, Harder + Co.

HPPC Process Evaluation Team:
Pali Basi
Raquelle Caras
Cely Queiroz
Kathleen Roe
Kevin Roe

1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Chata convened the meeting shortly after 3:00 p.m. He asked that members and guests introduce themselves. He welcomed everyone and asked if there were any announcements.

Announcements

Sonja Mackenzie

- Flyer distributed pertaining to the Community Forum on HIV Reporting and Surveillance; "The 'New Era' in HIV." The forum is scheduled to occur on Wednesday October 8, 7:00 p.m. at the Everett Middle School, 450 Church Street. The forum will feature Dr. Sandra Hernandez, former Director of the Department of Public Health. The resulting community input from this meeting will be forwarded to the upcoming Mayor's Summit on HIV/AIDS. For more information please contact: Jeff Sheehy, at 415-821-2217.

John Blake West

- Distributed an invitation to Council members to celebrate the 7th Annual Pre-Folsom Street Fair Brunch. The brunch will serve as a fund-raiser to benefit the AIDS Emergency Fund. It is scheduled for Sunday, September 28, from 10 a.m. to 2 p.m. at 401 Upper Terrace, #4. (*Donations are not obligatory.*)

J. Colin Partridge

- J. Colin referred to the letter of support that the Council generated several months ago in support of the Sonoma State University conference. He notified the Council that the conference is scheduled for the first weekend in May of 1998, from 9 a.m. to 4 p.m. It will include speakers and focus groups, as well as participation from prevention providers from Sonoma and San Francisco Counties. Sonoma State University will be funding the conference that will focus on gay and lesbian issues, as well as issues pertaining to HIV politics and policies. He indicated that a letter will be sent to all Council members in the near future inviting their participation in the conference prevention focus groups. He thanked the Council for their support.

Lyn Paleo

- Lyn explained that the Steering Committee had finalized the HPPC meeting calendar for the remainder of the year. She indicated that she would be forwarding a copy to be included for all members in the minutes.

Ellen Goldstein

- Ellen provided the Council with an update of the Mayor's Summit on HIV. She explained that the summit date had changed from December 2, 1997 to January 27, 1998. She stated that in December 1997, each of the seven sub-committees planning the summit will be conducting forums to solicit broader community input for the recommendations that will go to the summit. The Prevention Sub-committee is interested in presenting and discussing its recommendations with the HPPC prior to their forum. (Possibly at the 10/23 Council meeting.)

Barbara Adler

- Barbara extended an invitation for members to visit the AIDS Health Project mobile test-site at the Folsom Street Fair. They will be conducting drop-in anonymous OraSure testing throughout the day. Barbara indicated that she would be on hand to provide a brief tour of the 10 x 10 booth and its operation to any interested HPPC members.

Valerie Kegebein

- Valerie announced that Barry Brinkley, formerly of Alameda County, has been chosen as the new San Francisco DPH Director of HIV Prevention. She informed the Council that he was involved in the Alameda County HIV Prevention Planning Council and has experience with both CARE and prevention councils. His responsibilities will include the overall direction of the prevention program in San Francisco, as well as overseeing the prevention contracts. Valerie indicated that he shares in the current Prevention Unit philosophy and the unit is looking forward to working with him. His proposed start date is October 20, 1997. She indicated that it is yet to be determined if he will take over the DPH Co-Chair position on the Council, however, the Prevention Unit is hoping that Tracey will finish out her term.

Tracey Packer

- <u>Member Absences</u>: Tracey noted that Elizabeth D., Liz H., Dawn P., and Steven S., had all called to inform the Co-chairs of their absence from today's meeting. Elizabeth's and Steven's absences were due to illnesses. Liz and Dawn both had work related emergencies.

- In celebration of the September birthdays (including Co-chair Ellen G.), the AO staff to the Council provided the Council members with birthday cake and wishes.

- Tracey reminded the Committee Chairs of the next Steering Committee meeting. It will be at the AIDS Office on Wednesday, October 1, from 10 a.m. to 12 p.m.

Kathleen Roe

- Kathleen stated that congratulations were in order for the Council. She stated that while reviewing materials for a class presentation, she came across the publication "The Health of Asian and Pacific Islanders in California". (A 1997 Publication of the California Endowment.) Listed in the HIV/AIDS Chapter was a paragraph that began with, "..the San Francisco HIV Planning Council estimates that ....". Kathleen noted that this was a clear example of how the work done by this Council is being utilized by a wide variety of audiences throughout the country.

2. REVIEW AND APPROVAL OF AUG. 14 MINUTES

Tracey asked if anyone had questions, comments or corrections to the Aug. 14 minutes. There were none; a motion and a second were made to approve the minutes as is. The Aug. 14 minutes were thus approved by consensus.

Tracey noted that the September 11, 1997 minutes were distributed at this meeting to all members present, and would be approved at the next Council meeting. (Members not present today would be mailed the 9/11 minutes.)

3. MEMBERSHIP COMMITTEE UPDATE

Chata introduced Jelousy from the Membership Committee. Jelousy first acknowledged the other members of the Membership Committee, Ellen G., Steven S., Brian D. (AO), Barbara A., Elizabeth D., and Cely Q. (Process Evaluation team). Jelousy distributed a recruitment flyer developed by the Membership Committee, that indicates information for individuals interested in participating in HIV Prevention Community Planning.

Jelousy explained that the committee's efforts were not limited to recruitment. The committee has also been discussing and developing protocols for the issues of 'Proxy Voting' and 'Public Comment.' Jelousy stated that the Committee was interested in conducting a concept vote with the Council pertaining to these committee developed protocols. (He distributed drafts of the proxy voting and public comment protocols.) He explained that the intent of the proxy vote protocol was to ensure that the voices of absent Council members were represented during important discussions and votes. Ellen stated that the Membership Committee had discussed the possibility of absentee voting, but had agreed that many times views change due to the discussions that occur prior to a vote. The Committee discussed and decided upon proxy voting as an alternative for absent members wanting to participate in votes although they were physically unable to do so. She explained that proxy voting is when a member assigns a proxy – another member – to represent them during a vote. She referred to the last meeting on 9/11, particularly the CDC Cooperative Agreement vote. She noted that Sacul and Askia had both had to leave prior to the Council vote. They both expressed their support for a letter of concurrence to Ellen previous to leaving. Although she was able to state their preference for the record, their votes could not be counted. The use of proxy voting in that particular situation would have been ideal.

Ellen indicated that the draft listed a two step process for proxy voting. First, members choosing a proxy would have to notify the Co-Chairs in writing of his/her decision pertaining to their chosen proxy, or

representative. (*Proxy must be a voting member of the Council.*) Secondly, members choosing to proxy vote on a particular issue would have to notify the Co-Chairs in writing and prior to their absence of their intent to utilize their proxy for a particular vote at a particular meeting. She stated that the Committee was interested in receiving input from the Council about this protocol and opened the floor for discussion.

Maria indicated that she was not in favor of the proxy vote protocol. She expressed her belief that the proxy vote was the same as an absentee vote. She indicated that each member of the Council is representing a specific community and each member processes information differently. Therefore, if a member was to choose a proxy and was unable to participate in the pre-vote discussion, they would be relying on their proxy's interpretation of that pre-vote discussion. She added that if this was the case, then the Council might as well consider the absentee voting option. She stated that the intent of having the Council meetings was for members to participate in discussions and conversation about specific issues/votes. To send the vote information out and have members vote without having to come to meetings was counter-productive to the community planning process. She posed the question, Why come to meetings, when you can send your decisions in by mail or with someone else? She stated that she did support proxy or absentee voting if a person was very ill. However, she indicated her belief that this should not be an option for business related absences.

Sacul expressed her disagreement with Maria's interpretation of the draft. She indicated that the draft outlined that the proxy voting would not be a regular occurrence or a cop-out for HPPC members. The draft indicates that the HPPC expects "*...each member to be present at all Council meetings to fully participate as a responsible members of the community s/he represents.*" John B. West agreed and added that if he was to choose a proxy, he would not be bound to choose someone if he did not feel they could adequately represent him.

In response to a question, Ellen indicated that the proxy votes would not be used in a quorum count. There would have to be a quorum present for proxy votes to occur. Sonja asked if there was a way to set a limit the number of proxy votes allowed in a given vote. Ellen indicated that the Membership Committee had discussed that and had agreed that it would be difficult. A limit on how many proxy votes allowed on a given vote would place the onus on the Council to determine whose proxy votes to allow and which to exclude.

Michael D. stated that he was supportive of the proxy vote. However, he recommended that a limit be set as to the number of times a given individual could utilize the proxy vote. This would eliminate the threat of members abusing their right to proxy. He noted that there are some members who are very dedicated to this process and there are those members who choose to not participate on a regular basis. He expressed his concern that these latter members not be given the opportunity to take advantage of the proxy vote.

Askia stated that his initial thoughts on this matter surprised him. In trying to determine who he would choose if the need should occur, he realized that his initial choice did not always share in his ideology. He expressed his discomfort at having to rely on a proxy to make decisions on new information that would be discussed in his absence. However, he could see the benefits of such a method particularly when it came to illness, family, and business emergencies.

Colin stated that he too was comfortable with the concept of a proxy vote. However, he added that he was in agreement with Michael D's idea of a need for boundaries. He suggested limiting the number of proxy votes a member could use per quarter.

Jimmie stated that assuming this was approved by a majority of the Council, he indicated the need to consider the aspect of Co-Chairs in this protocol. He recommended that the Co-Chairs be excluded as possible proxies due to the nature of their role as facilitators of the Council votes.

Ellen indicated that in the interest of time -- and the Committee's interest in a Council concept vote – she suggested the Council move on. She explained that a concept vote was a manner in which the Committee could determine if the Council was supportive of the direction of their work. She noted that the concept vote is **not** the final decision.

Ellen summarized the feedback provided by the Council members to be considered by the Committee as they continue their discussions and work on the proxy vote protocol.

- *Limit the number of times members can utilize proxy voting, either by number of times or issues.*
- *Limit the use of proxy voting based on a given member's attendance record.*
- *Make sure that there are more members present voting than proxy voters.*
- *Exclude Co-Chairs from being chosen as proxies.*

Michael D. moved to approve the Proxy vote as a concept with the working revisions. There was a second. Ellen facilitated the vote.

In favor:	13
Opposed:	0
Abstained:	2

Ellen thanked the members and noted that the vote confirmed that the Council agreed that the Committee was moving in the right direction.

Ellen indicated that due to the time constraints, they would not be able to discuss the public comment protocol draft. She summarized that currently the Council does not have a mechanism in place for including public comment during their votes and discussions. (Case in point, Tamara Ching's request to comment previous to the concept vote.) Currently public comment is limited to the beginning of the 'business' Council meetings, on the first Thursday of each month. Although the public may be present during the votes and discussions, they are not allowed to participate. All votes and meeting discussions are closed to non-members.

The Membership Committee is proposing that general public comment (announcements or statements not related to the meeting agenda), remain at the beginning of each 'business' meeting. No more than ten minutes will be allotted to these public comments, with a three minute limit per speaker. Ellen stated that during the rest of the 'business' meetings, the Membership Committee is proposing to include public comment in the last ten minutes (or some percentage of the time), of each discussion. This will allow members of the public to participate in the discussions. As for the second meeting of the month, any 'business' sections of the meeting would follow the above mentioned protocol. During other sections of the meeting, such as research findings presentations, updates on HIV prevention in specific communities, etc., the entire discussion would be open for public involvement.

Ellen stated that this public comment protocol will be discussed and put to a concept vote at the second meeting of October. She indicated that anyone with specific feedback on this proposed protocol should

provide their feedback to the Membership Committee before the next Council meeting. The Committee will then incorporate the feedback before the second meeting of October.

4. 1997 SUPPLEMENTAL FUNDING UPDATE

Chata introduced Valerie for a brief update. Valerie distributed a list of the 1997 Supplemental Funding Awards. She noted that with the help of the Council the supplemental funding process had been close to flawless. The AO Prevention Unit staff provided funding recommendations to Dr. Katz on a Friday. They received his feedback on the following Monday and had sent out the award letters that same day. On Friday the AO staff also notified the agencies that they would be required to attend a mandatory meeting on either 9/24 or 9/25, from 9 a.m. to 12 p.m. All of the agencies participated and the AO staff worked with the agencies to begin drafts of the scope of work/narratives which are due by 9/30.

Valerie noted that the only significant change since the last update had been that the AO had decided to develop new contracts for supplemental dollars instead of modifying existing contracts. There were no agencies that were not recommended for funding. The AO is still deliberating how to address areas fro which no applications were submitted, particularly for the Native American MSM population.

Chata asked the Council for any comments or input. Members thanked the AO staff for their work. Sonja noted that the queer youth populations needed to include the specific gender they were targeting. She suggested adding the word male, since that is who they had intended to target. Valerie agreed that it should reflect that. Chata thanked the AO and everyone else who had been involved in the process. He expressed his concern pertaining to the services for the Native American community. He noted the need for clarification as to what the DPH and the Native American community can do to assure services for this community. He stated that it was unfortunate that the Native American AIDS Project did not choose to participate in the supplemental funding. However, he would like to see the AO and the Native American community find alternative to covering those gaps. Valerie responded to a member's question about the possibility of sole sourcing for Native American MSMs. She indicated that it was indeed an option, yet the Department had not determined how they would implement it.

5. UNOBLIGATED FUNDS UPDATE

Valerie informed the Council that the AO was still waiting for an award letter from the CDC pertaining to the unobligated funds. She reported that in a conversation with Nick Farrell of the CDC, he had stated that the CDC is currently holding up $2 million nationwide of unobligated funds. He assured her that he would be advocating for the DPH/AO to be allowed to utilize this funding in 1998. Valerie also stated that the cover letter for the CDC Cooperative Agreement Application will also request the use of the funds in 1998. Specifically the cover letter will indicate that the DPH/AO would like the unobligated funds to be awarded separately, noted as separate funding, and that they be allowed to use it in 1998.

6. STRATEGIC EVALUATION COMMITTEE UPDATE

Chata introduced Colin, Co-chair of the Strategic Evaluation Committee. Colin explained that he and Michael D. were co-chairing this Committee. He acknowledged the rest of the Committee members, Kristin C. (AO), Michael D., Brenda E., Liz H., John N., Henry O., Bethsaida R., Mike P. (AO), Stacey V., Raquelle C. (Process Evaluation team), and Martin F. (Polaris). At this time a presentation outline was distributed.

Colin explained that the Committee has been addressing the Impact and Process Objectives of the 1997 HPPC goals. There are three specific levels that have been identified. First is the guidance in implementation of the HPPC requirements at the program/provider level. Second, is the guidance in planning for intervention research. And third is the review progress in the development of the prevention

indicators project. Currently, with the assistance of Mike Pendo and Martin Forst, the Committee has begun working on the second level, guidance in planning for intervention research. They have created a comprehensive list of twelve interventions. Mike and Martin have completed the review and summarization of specific prevention published research findings. Listing them by interventions they have developed grids which depict: the research date, name, target population, whether it had long-term or short-term follow-up, the outcomes and measures, the implications, and the limitations. (Grids for at least three of the twelve interventions have been completed.)

The next step for the Committee will be to develop the criteria and a process for determining what prevention research gaps there are. The criteria will include such aspects as the number of studies that have been done. The relevance of the studies, and the efficacy of prior interventions. They will also look at the consistency/inconsistencies of the results, whether BRPs were studied or not, and the seroprevalence and the behavioral outcomes of the studies. Once the Committee has completed their review of the summarized literature and they have applied the criteria to determine the gaps, the Committee will begin to draft the principles for prioritizing the intervention level research. The Committee will present to the HPPC in November for a concept vote on the identified gaps and to solicit input on the principles for prioritization.

Colin referred to the Committee timeline on the second page of the handout. He indicated that the 1997 draft of Intervention Research Gaps would be completed in December 1997. The Committee would then solicit community input via open forums, focus groups, etc. Once the final revisions to the document were incorporated, the document would be disseminated. The Committee will then begin addressing the third level. He thanked the Council and introduced Mike Allison from the Support Center for the Organizational Development and Technical Assistance Project presentation.

7. ORGANIZATIONAL DEVELOPMENT/TECHNICAL ASSISTANCE PROJECT (OD/TA)
Mike Allison stated that the OD/TA Project had been originated in the first year of the HIV prevention planning process. Initially the focus had been to improve the evaluation methods and build collaborations between the San Francisco prevention providers. He distributed a three page Project Status Report that is a summary of the six month Project Progress Report that had been distributed previous to this meeting. He stated that the intent of this presentation is to inform the Council about the efforts and progress of the OD/TA Project.

Mike explained that the purpose of the project is to improve the capacity to provide effective HIV prevention programs among HIV prevention providers. Currently the project is working with 31 providers; seven (7) DPH housed programs and twenty-four (24) Community Based Organizations (CBOs) all of whom have prevention contracts with the AO. The first area of focus is assessing each program's ability to do Behavioral Risk Assessments (BRA) with the program clients or target population. This also includes improving each program's capacity to evaluate their own efforts. The second area of focus is to improve the general organizational capacity of each agency in order to support their prevention efforts. Mike noted that this is a nationally recognized effort that reflects the leadership of this Council to assure that everyone who is working in prevention, is doing so effectively. He added that as a consultant it is very exciting to work in the context of something so ambitious.

The OD/TA efforts began in January, when the project consultants began discussions with the agencies to determine what kind of services they were interested in, both in evaluation and organizational development. Mike stated that the project has recently finalized the capacity building plans which are actually contracts for the consulting services. Originally the project thought that it would be a simple process. This was not

the case. Due to various reasons including changes in personnel, contracts, and the time it took agencies to determine what they wanted and needed, the process became more complicated.

Mike stressed to the Council that as a contractor he felt the collaborative effort between the Council, its Committee and the six consulting firms, was extremely successful. The consulting firms provide a diverse pool of consultants for this project who offer a variety of perspectives. Due to this diversity, the project has been able to develop teams that are accurately suited for the particular agency's needs. In addition to this, there is a pool of resources that each team can draw on. For example, the STD HIV Prevention Training Center has a series of classes that the project can refer its agencies to without having to re-invent the wheel.

Mike shared a few of 'field stories.' He gave the example of Iris Center, which is being provided the OD/TA by Ron Strolich. During the initial assessment of the agency's ability to conduct a BRA, Ron had identified the need for an orientation pertaining to the BRA. The BRA training was developed and has been utilized by other consultant teams with their agencies. At BCA, Mike Pendo has been working with the staff and their other consultants to train staff in evaluation. Stacy Vogan has worked with Women and Families Community Health Project (WFCHP) in developing a BRA tool that will be utilized in the development of the program design. The tool will be used to meet the requirements of the HPEC/AO, but also to better understand the nature of the target population's risk.

As for the OD being provided, Christine Chan (Support Center) is helping UCSF AIDS Health Project with a whole range of OD support including training through the Support Center, retreats, etc. The API Wellness Center has been working with Brian Sugam from the Communication Science group who has arranged a supervision training that will assist in strengthening the agency's internal capacity. Brenda Crawford has worked with the staff at Glide Memorial Church which has recently brought on a new prevention director. The program has faced some changes in the program design as well as some internal organizational and cultural issues around accountability of roles and responsibilities. Mike indicated that these are the types of OD issues that can have an impact on how well a program is able to do its prevention work.

Mike summarized that this presentation is more of a process update, rather than a outcome update. He indicated that the results of this might not be evident till the end of the year. He suggested that the Council consider requesting another report later in the year that might have some clearer indications that all of this work has indeed improved the prevention services in the City of San Francisco. He asked if the other consultant team members or agency representatives that were present wanted to ad anything.

Michael D. stated that as a representative of the UCSF AIDS Health Project he has worked with Christina Chan from the Support Center and Ed Mammary of the Prevention Training Center. He stated that Christina has arranged retreats and a training for new staff members. The area that the AIDS Health Project has received more significant help with is the development of their BRA. The AIDS Health Project has an interest in developing not only a behavioral risk assessment, but one that includes the assessment of psycho-social risk factors. Their intent was to look at the elements of the BRA that were mandated and then include additional information that they felt was necessary. They presented those additional elements to Ed Mammary who provided them with some valuable feedback pertaining to how they might include their elements with the mandated elements of the BRA. Michael D. indicated that the AIDS Health Project is pretty close to completing their BRA tool. He added that the positive long term effects of the OD/TA process will hopefully be the facilitation of collaborations between the prevention providers of San Francisco. The AIDS Health Project is looking forward to being able to share their BRA with other agencies that support the idea of assessing both the psycho-social risk factors and the behavioral risk

factors. Mike A. stated that the consultants have a similar philosophy of sharing information. He noted that there have been a few opportunities throughout the project where consultants have shared what the agencies have developing or learned. He added that the consultants are continually looking for ways to collaborate in this fashion.

Michael D. stated that he would also like to see that particular philosophy -- of prevention linkages and collaboration – as an agenda that the Council should move towards. He stated that San Francisco prevention providers have many diverse perspectives and it would be very useful to bring everyone together to discuss what each is doing.

Natalie Gutierez of WFCHP indicated that she had been a part of the evaluation committee when she was a member of the Council. She stated that since the inception of the OD/TA Project she felt this would be a useful and beneficial exercise. However, she admitted that from an agency perspective at times it had felt like a chore. She explained that what made the difference in being able to overcome the "chore' mentality was the ever present nudging of their consultant Stacy Vogan. Natalie stated that Stacy pressed the program staff to ask the questions that needed to be asked. Natalie indicated that the program has completed collecting their data. The next phase will be to enter and then analyze the data. In keeping with the philosophy of sharing, Natalie indicated that their program had an extremely successful response rate to the mandated and additional questions that they had asked their clients. She stated that it was her belief that this was a result of their data collection strategy. The program sent letters to the clients before the assessment that briefly indicated why they would be asking the type of questions included in the assessment. Overall, she was surprised at the clients' cooperation being that they are not usually asked these types of questions. She reiterated that it was her belief that the cooperation of the clients was largely due to the 'warning' letter that had been sent out. Natalie stated that anyone interested in any further discussion about her program experiences could call her at ICHO, 415-922-6135.

Mike P. reported that his experiences has been varied depending on each agency. In assessing the agencies he found that some were very developed and were already collecting most of the data. Other agencies were less developed and required more assistance. He indicated that he has reviewed agencies' instruments in order to determine what mandated variables are not included and then he has assisted the agency in complementing what they are already using with the mandated variables. He has also arranged and conducted trainings for staff members.

Stacy V. expressed her agreement that there is a range of the capacity level for evaluation for each agency. She stated that it has been very helpful to have a number of consultants to share the instruments with and to discuss options being utilized by other agencies. Her intent has been to integrate the BRA with what the particular agencies are doing, by providing individualized one-on-one support.

Ron Strolich stated that initially he felt as if people might not be willing to participate but it turned out that many of the agencies embraced this as a way to get insight on their target population. He indicated that many agencies are looking beyond the mandated information and are using the BRA to gain anecdotal information about the populations by including additional questions.

Chata commended the OD/TA project for their efforts. He referred to the six month report and expressed his admiration at the manner in which it had been compiled to reflect the successes achieved as well as the barriers encountered. He referred to the lessons learned, items 1-6 in the six month report (pages 5 through 8), and noted that this was the most interesting aspect of the report. He added that this is a monumental task and reiterated his commendation of the OD/TA project. Barbara also commended the project. She indicated that having worked in counseling and testing for many years she is quite familiar with the concept

of BRA and she believes that it is an important tool for prevention providers. In asking clients the questions, providers are educating the clients as well as themselves. She agreed that it would be helpful for providers to share and compare their experiences and perspectives.

Tracey thanked Mike A. on behalf of the AO and the HPPC. She added that the Support Center has succeeded in taking an overwhelming task and coordinating it into a national model. She noted that in listening to the discussions and commentary from the members who are providers, she realized how productive it is to discuss the different aspects of the work. She asked if members would be interested in conducting similar discussions in an open forum type setting, such as the HPPC second meeting of the month. She suggested that since many Council members are prevention providers, the Council would be able to discuss different approaches and new methods that are being utilized by other providers. She indicated that members could respond to this issue in the meeting evaluation.

Ellen commended the OD/TA Project and the Strategic Evaluation Committee. She stated that both tasks, teaching providers to develop their own research skills to conduct their own BRA and reviewing the existing research to develop a database of interventions, are complementary. These are two of the most important and most immediately useful pieces of the triangle. (The third piece being the Council conducting their own intervention studies and behavior surveillance.) Ellen stated that the challenge will be to take the library of interventions and helping providers utilize and identify with the different research studies.

CDC APPLICATION UPDATE

Jimmie asked for a brief update on the CDC Cooperative Agreement Application. Brian stated that the application has been completed. Currently it is lacking some specific program budgets and some of the formal forms required by CDC. Valerie added that all of the budgets, including what was proposed last time for OD/TA Health and Planning Support Health, have all been approved by Dr. Katz. It will be mailed out by October 3. In response to a member, Brian stated that all HPPC members would receive a copy of the application narrative.

8. CLOSURE/EVALUATION

Chata thanked everyone and asked that members complete their evaluation forms before leaving.

Attached to these minutes for all members:

- Steering Committee Calendar (rev: 9/8/97)

Attached to these minutes for absent members:

- "The 'New Era' in HIV" community forum flyer,
- Seventh Annual Pre-Folsom Fair Brunch Fundraiser Invitation,
- "Be a Part of HIV Prevention Community Planning" recruitment flyer,
- Proxy Vote and Public Comment Drafts,
- 1997 Supplemental Funding Awards List,
- "Process Evaluation Results" and "Participant Dialogue" box from the September 9 meeting.

Minutes Recorded by: Amalia Fernandez-Niewendorp, Polaris R & D, Inc.
Minutes Approved by: Ellen Goldstein, Co-Chair, and Tracey Packer, AIDS Office Co-Chair.

August	September	October	November	December
8/14 **Council Meeting** • Roles+Resp Task Force- Present Roles and Responsibilities Doc. • Assessment Comm- Presentation/discussio n of revisions to priority-setting model • CDC Application - Short presentation of what it is, what to look for when it comes in the mail, what is a leet of concurrance.	9/11 **Council Meeting** • CDC Application/letter of concurrance/**Vote.** • Roles and Responsibiliities Document 9/25 **Council Meeting** • Membership Comm - Update on Progress. • Open Discussion	10/9 **Council Meeting** • Assessment Comm- Present revisions to priority-setting model/**Concept Vote;** • Linkages Comm- Present Cultural Competence Principles & tool/ Progress Report 10/23 **Council Meeting** • Membership Comm- Ppresents PR Plan; **Concept Vote** • Membrshp Comm- Present Bylaws/**Vote.** • Open Discussion	11/13 **Council Meeting** • Assessment Comm- Present revisions to priority-setting model/**Final Vote.** • Linkages Comm- Present Cultural Competency Principles & Tool/ **Concept Vote.** • Nominate Co-Chair 11/20 Specially Scheduled Council Meeting • Strategic Eval Comm- Present priorities for intervention level eval research/ **Concept Vote;** • Membership Committee presents Plan for PR/**Final Vote.** **11/27 Thanksgiving**	12/11 **Council Meeting** • Linkages Comm- Present Cultural Competency principles and tool/**Final vote;** • Assessment Comm- Present Resource Inventory/**Vote** (or in January) • Strategic Eval Comm- Present priorities for intervention-level eval research/**Final Vote;** • Elect Community CoChair. **12/18 New Member Orientation** **12/25 Christmas**

rev: Sept 8, 1997

HIV PREVENTION PLANNING COUNCIL MEETING

OCTOBER 9, 1997
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

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Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer

Please read: **Agenda/Linkages Committee Report/Assessment Committee Report**

1. Food/Welcome/Introductions/Announcements	Tracey Packer	3:00 - 3:10 PM
2. Public Comment	Tracey Packer	3:10 - 3:30 PM
3. Review and Approval of 9/11 and 9/25 Minutes	Tracey Packer	3:30 - 3:40 PM
4. Linkages Committee-Progress Report	Sacul L'Adnbre	3:40 - 4:40 PM
5. Evaluation		4:40 - 4:45 PM
6. Break		4:45 - 4:55 PM
7. Assessment Committee-Concept Vote	Maria Rinaldi	4:55 - 5:55 PM
8. Closure/Evaluation	Tracey Packer	5:55 - 6:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC Meeting - Thursday, October 23, 1997, **3-5** PM, First Unitarian Church 1187 Franklin Street (@ Geary)

MEMORANDUM

DOCUMENTS DEPT.

OCT 07 1997

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October 2, 1997

TO: HPPC
FROM: Linkages Committee
SUBJECT: October 9 Committee Progress Report to the Council

During the next Council meeting, the Linkages Committee will be presenting a progress report on our work developing a cultural competency assessment tool. To help prepare you for this presentation, we have prepared some background material.

The task assigned to the Linkages Committee by the Council for this year was to: 1) review definitions of organizational cultural competency developed by other groups; 2) develop a definition of organizational cultural competency; and 3) develop a tool that RFP review panelists can use to assess organizations' cultural competency when assessing proposals submitted to the AIDS Office for funding.

The Linkages Committee began this task by reviewing a variety of source materials developed by other organizations to see how others had approached the topic of cultural competency. The enclosed 8 page document, *Summary of Background Materials on Cultural Competency,* is a collection of short summaries of some of that work. Of particular use to the committee was the work of The California Office of Multicultural Health.

The Linkages Committee next developed a set of principles of cultural competency in order to facilitate the development of an assessment tool. These principles were the heart of the committee's work for many weeks. While they have not yet been finalized, the 2 page draft document, *Guiding Principles of Cultural Competency,* is an extremely important piece of the committee's work. We hope that you will read this piece before Thursday's meeting, as the assessment tool comes directly from this work.

Two other documents which you may want to read are *Key Informant Interview Findings (Memo, dated September 8, 1997)* and *Preliminary Summary of Issues Identified in Key Informant Interviews*. The first 9 page document is a summary of the findings from a series of 30 minute phone interviews with a variety of service providers conducted by the committee's technical assistant consultant. The purpose of these interviews was to draw upon

thinking within the community about the meaning of cultural competency, ways in which it can be measured, and some barriers to developing an assessment tool. The 7 page document, *Preliminary Summary of Issues Identified in Key Informant Interviews,* contains the questions asked in the interviews, along with a number of typical responses.

During the presentation, the Linkages Committee will discuss the Guiding Principles and present a draft version of an assessment tool that agencies will complete when responding to RFPs for prevention contracts. The completed assessment tool will be reviewed along with the proposal so that agencies' cultural competency can be considered when making funding decisions.

In order to ensure a lively and productive discussion, we hope you will be able to review these materials prior to the October 9 meeting.

Summary of Background Materials on Cultural Competency

Cultural Competency Principles

(Adapted form Cross, et. al. *Towards a Culturally Competent System of Care*)

- Works towards equal access to services and resources for racial and ethnic populations regardless of language and culture.
- Incorporates cultural knowledge and strengths into policy and practice, thus recognizing the interaction of culture and health.
- Respects all Californians and exhibits sensitivity for their cultural practices.
- Recognizes the diversity within various racial and ethnic communities and distinguishes between cultural identification and the culture of poverty.
- Supports programs that strengthen the capacity of multicultural communities to promote health.
- Establishes policies and procedures to promote racial and ethnic community participation in the allocation of resources and the design and implementation of interventions developed to address their health needs.
- Evaluates the effectiveness of its programs in improving the health status of racial and ethnic populations.
- Celebrates diversity.
- Creates an ongoing process to monitor its level of cultural competence, including the recognition of achievements and the identification of unmet needs.

Source: *Operational Definition of Cultural Competence in a Public Health Department.* The California Office of Multicultural Health.

EXAMPLES OF CULTURALLY COMPETENT PRACTICES

- Collects and analyzes racial and ethnic specific demographic data to better assess clientele and to identify undeserved or underutilized groups, etc. in order to improve service delivery and outreach efforts.
- Conducts community assessments involving members of the community in the planning, implementation, and reporting of these assessments and its findings.
- Consults with organizations or individuals who represent racial and ethnic population groups in the planning, implementation, and evaluation of programs.
- Considers cultural factors, such as language, race, ethnicity, customs, family structure, and community dynamics in developing its policies and services.
- Provides all staff, including managers, with cultural competency training.
- Actively recruits and retains a work-force (paid and voluntary) and Board of Directors reflective of the population served.
- Includes in job descriptions and performance evaluations the requirement that employees have an understanding of, and sensitivity to, serving diverse populations.
- Establishes partnerships with multicultural health and human services organizations and agencies to enhance its referral base.
- Employs client assessment instruments and procedures that identify culture-based beliefs and practices that affect service delivery.
- Employs culturally appropriate patient satisfaction instruments and procedures.

Source: *Operational Definition of Cultural Competence in a Public Health Department.* The California Office of Multicultural Health.

Standards for Culturally Competent HIV Prevention Interventions for Asian and Pacific Islander Populations

1. Access at all points of contact
   - all written materials culturally and linguistically competent
   - access to phone reception/messages
   - welcoming office reception, office signs/environment, venue/location
   - appropriate scheduling of office hours/events; provide ancillary services (food, transportation, childcare) or participation incentives
   - includes family/community in programs
   - has standards for use of interpreters
   - seeks and advocates for linguistically and culturally competent referral linkages

2. Staffing
   - hiring/retention/promotion; affirmative action/outreach; commitment to staff diversity and parity; integration of cultural competency across entire staff
   - ongoing staff training, development and skills building to increase cultural competency
   - outreach, recruitment and integration of volunteers from target community
   - use of consultants/vendors from target community

3. Content/context of HIV prevention interventions
   - based on knowledge/research on demographics and epidemiology of target population
   - identifies and addresses cultural barriers, e.g., taboos about sexuality, drug use, disease, death, mental health, etc.
   - uses indirect/contextual/pragmatic messages
   - uses multiple communication methodologies (graphics, illustrations, radio, television, video, etc.)
   - considers both individual and community norms/interventions (emphasizes shared/communal responsibility)
   - doesn't confront/embarrass/compete
   - promotes/reinforces appropriate health-seeking behaviors
   - planning goes beyond units of service/cost effectiveness

4. Decisionmaking
   - is agency client-centered?
   - management/supervisory staff and board representation from target community
   - participation of target community in planning, developing, implementing and evaluation of program in formal organizational structures
   - financial commitment to program development/expansion

5. Ongoing evaluation
   - commitment to institutional change to increase cultural competency: included in

agency's strategic or long-range plan.
- process to monitor/measure progress in increasing cultural competency
- long-term commitment to target community: participation and sponsorship of community events/promotion of community culture/art/history
- supports community partnerships: defers to community leadership and supports funding of organizations based in target community.

6. Actual access by target population/clients/consumers
   - measure change in access/intake data
   - monitor utilization/retention data
   - actively measure client satisfaction
   - measure client outcomes: increased knowledge, risk reduction, changed community norms
   - agency has appropriate complaint and grievance procedures.

Source: *Cultural Competency Resources for Asian and Pacific Islander HIV Prevention Programs.* January 1997. National Asian and Pacific Islander HIV Resource Center.

THE **AWARE** MODEL
COMMUNICATING ACROSS CULTURES

A **Accept** the other person's behavior without judging it based on what that behavior means in your culture.

W **Wonder** what the other person's behavior means in their culture rather than what it means in your culture.

A **Ask** what it means to them.

R **Research** and read about the other person's culture so that you are able to place their behavior in the context of their cultural worldview.

E **Explain** what their behavior means in your culture and demonstrate the behavior in your culture that expresses that feeling so that they can learn new behaviors that will help them function in your culture.

Source: Polaris Research and Development, Inc. 1993-95.

Standards of Cultural Competency Set Forth at the Gay Men of Color AIDS Summit

- HIV prevention strategies developed must be cognizant of and address cultural norms and social structures pertinent to diverse Gay Men of color communities (e.g., geographic isolation, poverty, immigration status, societal mistrust).

- HIV prevention strategies developed must utilize the language and communication styles of the targeted Gay Men of Color community (e.g., regional dialects, literacy levels, hearing impaired, non-sighted, etc.)

- HIV prevention strategies developed must be cognizant of and respond to the diversity (e.g., nationality, language, tribe) within the various ethnic and multi-racial groups.

- HIV prevention strategies developed must consider the complexity of gender and sexual identity.

Source: *Report on Standards as Set Forth at the* Gay Men of Color AIDS Summit, August 31-September 3, 1995.



Cultural Competency

- Understanding the history of a particular community and its relationship to similar communities statewide and nationwide.

- Understanding the history and current situation of a particular community in relation to mainstream culture.

- Understanding the oppressions faced by the community, and the community's methods for resisting this oppression on personal, familial, and community-wide levels.

- Understanding specific issues of gender, ethnicity, and sexual orientation within the community.

Source: *Frameworks for Change*. Multicultural Liaison Board. July 1995.



Conceptual Definition of Cultural Competency

"An organization's ability to honor, respect, and utilize in solving human problems, the beliefs, interpersonal styles, attitudes and behaviors both of families who are clients and the multicultural staff who are providing services. In so doing, the program incorporates these values into its policies, administration, and practices.

Source: *Operational Definition of Cultural Competence in a Public Health Department.* The California Office of Multicultural Health



Defining What Culture Is

Culture is the blueprint of beliefs, behaviors, and identities which shape the perceptions of a person or a group of persons. It is an inheritance of ideas, practices, and attitudes which are conveyed and reinforced from generation to generation through institutions of society, like family, church, and community. Culture defines right and wrong, delineates assumptions and expectations, and ultimately describes our dreams and the meaning of life.

Culture is humankind's changing response to his/her environment, his/her interior search for connection to creation, and his/her need to act, react, and interact with members of the same species.

Source: Chris Sandoval, Polaris Research and Development. 1994.



Definition of Cultural Competency

CULTURE: one's worldview, values, beliefs, customs and behaviors influenced by one's race, ethnicity, national origin, language, religious beliefs/spirituality, class/socioeconomic status, gender, sexual orientation, etc.

COMPETENCY: a required level of knowledge, skills and experience.

CULTURAL COMPETENCY: sufficient knowledge, skills and experience to communicate effectively with and work together with someone from a particular culture.

Source: *Cultural Competency Resources for Asian and Pacific Islander HIV Prevention Programs.* January 1997. National Asian and Pacific Islander HIV Resource Center.



CULTURAL COMPETENCE: A set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications, and other supports the basic principals of cultural competency.

Source: *Cultural Competence for Evaluators: A guide for alcohol and other drug abuse prevention practitioners working with ethnic/racial communities.* United States Public Health Services — Alcohol, Drug Abuse, and Mental Health Administration. DHHS Publication 92-60067.

CULTURAL COMPETENCY is a process that requires individuals and systems to develop and expand their ability to know about, be sensitive to, and have respect for cultural diversity. The result of this process should be an increased awareness, acceptance, valuing and utilization of and an openness to learn from general and health-related beliefs, practices, traditions, languages, religions, histories and current needs of individuals and the cultural groups to which they belong. Essential to cultural competency is appropriate and effective communication which requires the willingness to listen and learn from members of diverse cultures and the provision of services and information in appropriate languages, at appropriate comprehension and literacy levels, and in the context of individuals' cultural health beliefs and practices.

Source: *Recommendations for the Medi-Cal Managed Care Program.* California Cultural Competency Task Force. University of California, Berkeley. February 8, 1994.

CULTURAL COMPETENCE is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations.

Source: *Towards a Culturally Competent System of Care (Volume 1): A monograph on effective services for* minority *children* who *are severely emotionally disturbed.* CASSP Technical Assistance Center, Georgetown University Child Development Center. Washington, DC. March 1989.

A **CULTURALLY COMPETENT PROVIDER** appreciates differences, is responsive to needs, and provides intuitive interventions.

Source: *How do We Color Our Health Care?: A cultural diversity guide for Kaiser Permanente Health Professionals in the Los Angeles Service Area.* Los Angeles Kaiser Permanente Medical Center. 1994.



CULTURAL COMPETENCE is a set of knowledge-based and interpersonal skills that allows providers to understand, appreciate, and work with individuals of cultures other than their own.

Source: *Culturally Competent Health Care for Adolescents: A guide for primary care providers.* American Medical Association. 1994.



CULTURAL COMPETENCY is the ability of organizations and individuals to work effectively in cross-cultural or multicultural interactions. It refers to an organization's ability to recognize and use health attitudes, beliefs, behaviors, and communications patterns of its clients, their families, and its own diverse staff, to improve services, strengthen programs, increase community capacity, and close the gaps in health status among diverse populations groups. In so doing, the organization reflects these values in its policies, practices, and programs.

Source: CDHS/OMH, 1996.



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GUIDING PRINCIPLES OF CULTURAL COMPETENCY

Developed by the Linkages Committee of the San Francisco HIV Prevention Planning Council

OVERARCHING PRINCIPLES

1. Define culture broadly, encompassing an individual's race, ethnicity, gender, sexual orientation, age, language, and other defining characteristics.

2. Recognize and respect that culture is ever-changing and evolving.

3. Recognize the diversity within and among multi-cultural communities.

4. Recognize the dynamic interaction between culture and health.

5. Recognize the distinction between cultural identification and class.

6. Recognize and be sensitive to the diverse languages and dialects used by different communities.

7. Treat all San Francisco residents with respect, exhibiting sensitivity for their cultural practices.

8. Develop and support programs that address the needs of the local populations shown to be at risk.

9. Support programs that strengthen the capacity of communities to promote their own health.

10. Ensure that service providers are accountable for addressing the complexity of culture and subculture, including race, ethnicity, gender, sexual orientation, age, language, and other defining characteristics.

11. Question and challenge cultural stereotypes.

AGENCY-SPECIFIC PRINCIPLES

1. Make time for clients to advocate on their own behalf so that services can be developed to address clients' specific needs, as they have defined them.

2. Incorporate ongoing needs assessments with the target population into the organization's policies, resource allocation, program design and implementation practices.

3. Understand and address the needs of the various subcultures within the target population served by the agency.

4. Solicit, acknowledge and support clients' own definitions of who they are, refraining from categorizing them into pre-defined, inappropriate and/or restricting categories.

5. Strive to understand and respect the ever-changing nature of culture.

6. Recognize that organizational cultural competency requires a combination of appropriate staff representation and training in cultural competency to enable staff to understand and meet the needs of their target populations.

7. Staff programs at all levels, paid and volunteer, with people who reflect the cultures of the populations they serve.

8. Train staff at all levels, paid and volunteer, about the cultures of the program's target population and how to approach meeting the needs of that population.

9. Nurture client/provider relationships that respond to and are sensitive to the client's culture.

10. Approach clients in a non-judgmental fashion, building trusting relationships.

11. Provide equal access to services and resources for all persons within a program's target population, including its various subcultures.

12. Create mechanisms to link individuals who present for services but are not in the program's target population to other providers who can address their needs.

13. Create an ongoing process to monitor the organization's level of cultural competence, including recognizing achievements and identifying and addressing shortcomings.

14. Evaluate the effectiveness of the program to improve the health status of the target population, and incorporate that feedback into revised program models and practices.

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MEMO

To: HPPC Linkages Committee
Subject: Key Informant Interview Findings
Date: September 8, 1997

This memorandum presents findings from a series of key informant interviews conducted on behalf of the HPPC Linkages Committee to explore perceptions of service providers about culture, cultural competency, and how to assess organizational cultural competency. This summary is intended to be used by members of the Linkages Committee as they develop a tool to to assess cultural competency to be used in an RFP review process. As such, it should be viewed as a working document designed to assist this specific process, and it should be viewed in tandem with the *Preliminary Summary of Issues Identified in the Key Informant Interviews* distributed previously to the Committee.

Following a brief discussion of the purpose and methodology of the interviews, this memorandum discusses the finding in terms of four key issues: culture, cultural competency, indicators of organizational cultural competency, and barriers to assessing cultural competency. To the extent possible, this document provides references to areas where respondent answers were either in alignment with or differed from the discussions within the Committee.

Purpose

These interviews were conduced at the suggestion of members if the HPPC Linkages Committee for several reasons. On a broad level, the interviews were conducted to assess the extent to which the Committee's work in developing principles of cultural competency were in alignment with views in the community about this issue. Are the committee's ideas and views shared with others in the HIV prevention community, or not? The interviews also sought to draw upon the thinking that has already been done within the community about organizational cultural competency—what it is; how to assess it; the barriers to assessing it—to incorporate into the Committee's further deliberations.

Methodology

A total of eleven interviews were conducted with key informants who are knowledgeable about HIV prevention and issues of cultural competency across the City. Respondents represented a variety of different "cultures" in terms of their own identity and the cultures served by their agencies. The interviews lasted approximately 30 minutes, and all but one were

conducted by telephone. Both the list of potential interviewees and the interview protocol were developed with substantial input from members of the Linkages Committee.

Readers should be cautioned about he limited generalizability of these findings. Because only a very small number of respondents were interviewed and non-random recruitment techniques were employed, these respondents do not represent a probability sample. Therefore these data should be regarded as more suggestive than definitive in nature.

CULTURE

Respondents were asked to describe the cultures served by their agencies and the characteristics of those cultures, with the underlying goal of ascertaining both individual and organizational definitions of culture. For the most part, these answers were compatible with the discussions within the Linkages Committee about cultures and were along the lines of this respondent who said that, "Culture is a complex array of shared values, norms, traditions, behaviors and experiences in the world that are valued in a creative way." Culture was viewed as a multi-faceted system comprised of a variety of dimensions, including some elements that a person is born with and others that change throughout one's life. Respondents identified a variety of components of culture, including race/ethnicity, gender, sexual orientation, substance-use, socio-economic status, language, HIV status, etc.

In this view of culture as a complex system, respondents felt that individuals may identify more with one aspect of their culture at one time, and another aspect of their culture at another time. A few respondents noted that there are certain cultures that tend to dominate an individual's identity, in particular the drug-using culture and street culture.

For the most part, service providers felt that their programs target certain cultures—usually more that one particular culture, but certainly not all cultures. There was a consensus that any population is comprised of various sub-cultures, and programs are targeted to, and subsequently reach, one or more of those sub-cultures. Providers must therefore understand which sub-cultures they do and do not serve, with an eye on whether they intend to serve any of the sub-cultures that they are not reaching, and if so, how they will reach that undeserved population.

It should be noted that a few respondents' first responded to the question of culture by discussing race/ethnicity, even though their further elaborations on the issue included a wider variety of dimensions of culture. This is an important issue for the Committee to consider, in that the term "culture" may be understood by some individuals and organizations to be equated with "race/ethnicity." It will be important for the Committee to ensure that providers understand the Committee's broad view of culture, in order for the Committee's work on cultural competency to be clear.

Within the discussion of culture, respondents working for agencies defined as serving multiple communities were also asked to explain their understanding of "multi-cultural." Following their explanations that any culture includes a variety of sub-cultures, they felt that all

cultures are in some sense multi-cultural. Yet multi-cultural, they felt, does not imply being able to serve everyone; rather, it implies serving a variety of cultures. One respondent felt that multi-cultural means trying to respond to the many sub-cultures in a population, and another said that it means embracing the diversity of their clients. Yet another felt that for a truly multi-cultural program, there are no limits to who can be served.

CULTURAL COMPETENCY

Cultural competency, as expressed in these interviews, involves recognizing, understanding and being sensitive to people's own definitions of their culture, including the norms and values that are important to them and which guide the way in which they live. For most respondents, cultural competency in a prevention setting necessitates a client-centered model of care where clients define themselves and their needs, and providers aim to meet those needs in a non-judgmental fashion. Communication was identified as a key tool to ensuring cultural competency.

One way identified to ensure cultural competency would be for providers to share all of the same cultural aspects and experiences as their clients. This would never be completely possible, however, because the very nature of being a provider sets someone apart from a client. Yet a majority of respondents felt that having providers as representative of the target population as possible is one method for ensuring cultural competency.

This was not, however, seen as the only way to ensure cultural competency. The majority of respondents felt that cultural competency can be learned. While it may be helpful for a provider to share some of the cultural aspects with their clients, this is not a requirement if the provider can develop other mechanisms to understand and respond to their clients concerns and needs. A few respondents went so far as to say that a provider with a very different cultural background from his/her clients may be able to provide more culturally competent services than a provider of the same cultural background, depending on their techniques for working with the clients. One respondent shared a model he had learned for developing cultural competency which involves passing through four stages: 1) unconscious incompetence; 2) conscious incompetence; 3) conscious competence; and 4) unconscious competence.

INDICATORS OF ORGANIZATIONAL CULTURAL COMPETENCY

Respondents identified a wide variety of indicators of organizational cultural competency. There was overwhelming agreement that cultural competency is a complex issue which manifests in a variety of ways within organizations, and that an examination of no one indicator would be sufficient to assess cultural competency.

What follows is a list of the cultural competency indicators identified by respondents, divided into the general categories of program outcomes, program design and evaluation, program implementation, organizational and management issues, and staffing issues. Each indicator includes the approximate number of respondents (out of a total of 11) who mentioned this indicator, and whether or not the indicator follows from the principles of cultural

competency that were discussed by the Linkages Committee prior to conducting these interviews. Please note that this is an approximation due to the fact that the Committee had not discussed specific indicators of cultural competency when these interviews were conducted, only guiding principles of cultural competency. In addition, these counts are based only on the indicators mentioned by respondents ***without prompting***.

Program Outcomes

Indicator	Number of Respondents	Discussed by Committee
Is the program providing the services intended to its target population and achieving the desired outcomes? *Note: For a few respondents, this was the most important indicator of cultural competency.*	6	Yes

Program Design & Evaluation

Indicator	Number of Respondents	Discussed by Committee
Does the program collect needs assessment data on a regular basis in order to understand the changing needs of the community?	7	Yes
Are client comments and criticism incorporated into program improvements?	3	No
Does the program's structure facilitate reaching all of the target population or only a segment of it?	2	Yes
To what extent is identifying and describing population subcultures included in program planning?	1	No
Is there a regularly scheduled program assessment process?	1	Yes
Does the program have a historical commitment to meeting the needs of its target audience?	1	No
Are new program models pretested with the community before full-scale implementation?	1	No

Program Implementation

Indicator	Number of Respondents	Discussed by Committee
Are program materials provided in the languages and cultural contexts of the target populations?	6	Yes
Is the program client centered, meeting the needs of clients as defined by clients?	5	Yes
How comfortable are clients accessing the services offered?	3	No
How satisfied are clients with the services provided?	3	Yes
Are clients given program alternatives so that they can choose the intervention that best addresses their needs?	1	No
Does the program use a cultural assessment tool to determine the many facets of a client's culture?	1	No
Does the intervention reach beyond one socio-economic level?	1	Yes
Do services address the variations of a culture from one neighborhood to another?	1	No

Organizational & Management Issues

Indicator	Number of Respondents	Discussed by Committee
Does the program build links to the community, such as through collaborations with other organizations?	5	No
Is cultural competency training provided for all levels of the organization: board of directors, senior management, middle management, line staff (both paid and volunteer)?	4	Yes
Are members of the board of directors culturally representative of the client population?	3	Yes
Does the agency have a plan to address cultural competency?	2	No
Are clients involved in making policies and protocols?	2	No

Indicator	Number of Respondents	Discussed by Committee
Does the agency's mission address the issues of culture and cultural competence?	1	No
Does the agency incorporate holidays celebrated by the target population into its activities?	1	No
Do internal records promote cultural competency by collecting data that is culturally relevant to the individual?	1	No
Are development activities directed toward diverse communities, including the target population?	1	No
Has the board of directors adopted new policies related to cultural competency?	1	No

Staffing Issues

Indicator	Number of Respondents	Discussed by Committee
Does the program hire staff, at all levels, from the community being served?	7	Yes
Are staff who reflect the community being served actively included in organizational management and leadership?	2	No
Do staffing structures maximize the cultural and linguistic capabilities of the staff?	2	Yes
Do staff pay-scales encourage applicants who both identify with the target population ***and*** have the required skills?	1	No

BARRIERS TO ASSESSING CULTURAL COMPETENCY

In general, the respondents interviewed said that assessing organizational cultural competency is a difficult and complex task. It is a subjective process that involves making assessments about an organization based on looking from the outside in, and attempting to evaluate the intelligence and self awareness of staff. They acknowledged that cultural competency is a sensitive issue, with many different views about what constitutes cultural competence when working with different populations. It involves balancing qualitative and quantitative data, and respondents believed that there will always be different opinions on how best to achieve that balance. About half of the respondents questioned whether it is even

possible to assess cultural competency, although, for the most part, they commended the Committee for its efforts in this area.

Some of the pitfalls of assessing cultural competency mentioned in the interviews included the fact that providers already know the answers that assessors want to hear, as well as the limitations of the data, assumed to be primarily self-reported data, that would be used in the process. The question was raised of how to determined whether information provided is accurate or not. Lack of resources was also identified as a barrier to assessing cultural competency, with many programs lacking the capacity or resources to do community needs assessments and program evaluations to determine, and then attempt to improve upon, their cultural competency.

Another barrier mentioned involves the very nature of some programs and their target population. For some individuals, HIV prevention is not as high a priority as other issues in their lives, such as shelter, immigration, feeding their family, etc. No matter how good the intervention may be, these individuals will always remain very hard to reach. A program, therefore, may not necessarily lack cultural competence if has difficulties reaching these people with prevention messages.

Two respondents noted that the difficulty with this process is that the people who want to assess organizational cultural competency are really interested in something else. They are interested in achieving social justice—how to give disenfranchised populations more power and resources—not cultural competency. Assessing cultural competence, while perhaps interesting, will not answer or solve their questions and concerns.

In discussing barriers to assessing cultural competency, respondents also gave some suggestions for how to implement a proposal review process. In terms of the individuals chosen to review proposals, respondents urged that they clearly understand their role as universal advocates—advocating for the rights, privileges and well being of the whole community, not just the communities to with which they personally identify. A few respondents also suggested that they should receive cultural competency training and be advised to be respectfully hesitant of the review process in all of its complexity.

In terms enhancing the proposal process, several respondents suggested adding a site visit component in order to gather information that cannot be captured in a written proposal. They suggested interviewing all stakeholders in the agency, including members of the board of directors, management, staff, clients and other funders.

Respondents also mentioned the importance of developing cultural competency standards to ensure that all programs are evaluated with the same criteria. One respondent also suggested issuing a disclaimer, stating the limitations of the cultural competency assessment, while another stressed the importance of pilot testing any tool before it is made public.

Summary

Overall, these interviews confirm that the direction being pursued by the Linkages Committee follows the general thinking in the community about the meaning of cultural competency and the methods that can be employed to asses it. Respondents were generally supportive of the work being undertaken by the Committee, with the understanding that this is a complex, and at times arduous, task.

DRAFT

HPPC Linkages Committee
Preliminary Summary of Issues Identified In Key Informant Interviews

NOTE: The following draft presents a summary of the issues raised during a series of interviews conducted with providers about issues of organizational cultural competency. The items listed represent views from different individuals and, therefore, may in some cases be contradictory. These issues are not presented in any particular order, and these findings should be viewed as preliminary in nature.

What is Culture?

- Culture is a complex array of shared values, norms, traditions, behaviors and experiences in the world that are valued in a creative way.

- There is a functional relationship between culture and behavior:
  - culture determines values
  - values shape behaviors
  - behavior is the explicit language of culture

- Culture, like water, fills the shape of its environment. It is constantly evolving - a mobile sense of consciousness. Culture transcends labels.

- Culture is defined first and foremost by language, but also includes a multitude of other elements including social class, sexual orientation, gender, HIV status, housing situation, substance use, etc.

- Culture is not something you are born with; culture can be learned.

- In prevention, what is important is how culture is manifested, how cultural values present themselves in terms of how people communicate, how they dress, how they live their lives, etc.

- Culture is much more than race and ethnicity. For example, the drug using culture can be a much more compelling aspect of someone's culture than their ethnicity.

- Culture has to do with one's living environment and the values and norms in that environment.

What Does Multi-cultural Mean?

- Multi-cultural implies serving several different cultures. However, given the vast array of cultures and the various ways that these cultures intersect in different individuals, multi-cultural does not imply being able to serve everyone.

- Multi-cultural means trying to respond to the many sub-cultures in a population, looking beyond just race and class.

What is Cultural Competency?

- Being sensitive to the various meanings within a culture.

- Being able to recognize and identify the living and social environment in which someone lives and understanding that those values and norms are important to guiding how that person lives.

- Respecting other people's definitives of their own culture.

- Approaching others with a non-judgmental attitude.

- Ensuring that honest communication is taking place. When people define and act on problems together, the issue of cultural competency drops out.

- A provider first needs to understand their own culture in order to be able to understand how their culture differs from the cultures of others. This is an important part of developing cultural competency.

- If an agency is involved in grassroots community organizing, then it is by definition culturally competent because members of the community are doing the work.

- To develop cultural competency, one has to move through four stages: 1) unconscious incompetence; 2) conscious incompetence; 3) conscious competence; and 4) unconscious competence.

Indicators of Cultural Competency

Program Outcomes

- Is the program providing services to its target population (i.e., is it meeting its units of service) and achieving the desired outcomes? Is the program affecting the needs of the community?
  Note: For several people interviewed, this was clearly the most important indicator of cultural competency.

Program Design & Evaluation

- Does the program design address the changing demographics of the epidemic in the City?
- Does the program design reflect the needs of the community?
- Does the program collect needs assessment data on a regular basis to understand the changing needs of the community? Does the program know the pulse of the community? Are the data collection mechanisms appropriate to the community being served?
- To what extent is identifying and describing population cultures included in program planning? How are the various aspects of culture then addressed in program design?
- Are services designed to address the different cultures of different neighborhoods? For example, how does a program addressing the needs of African Americans in one neighborhood differ from a program addressing the needs of the same population in another neighborhood?
- Is there a regularly scheduled program assessment process? Does the program periodically step back from its work to reassess whether it is still meeting the needs of the community in the best way possible?
- Does the program have a historical commitment to meeting the needs of the community? If not, how will it develop the expertise to serve the community?
- Are new program models pretested with the community before full-scale implementation?
- How are client comments and criticism incorporated into program improvements?
- Does the structure of the program facilitate reaching the target population or only a segment of the target population?
- How does the program ensure quality?

Program Implementation

- Does the program allow the client to identify their own culture?
- Does the program use some form of a client cultural assessment tool to determine the many facets of a client's culture?
  Note: See MARCC example.
- Is the program client centered, meeting the needs of clients as they see them?

- How comfortable are the clients? How satisfied are they with the services provided? Are their mechanisms in place to determine client satisfaction?
  Note: A limitation on client satisfaction surveys is that it only assesses the satisfaction of those clients who were served, not those people who were not served, perhaps because of cultural competency issues.

- Is there class competency? Can the program reach beyond a certain class with its intervention?

- Are program materials (brochures, videos, signs, etc.) provided in the languages and cultural contexts of the target populations?

- Is the client provided with program alternatives so that they can choose the intervention that best addresses their needs?

Organizational & Management Issues

- Does the agency mission address the issues of culture and cultural competence?

- Is cultural competency training provided for all levels of the organization: board of directors, senior management, middle management, line staff (both paid and volunteer)?

- Are development activities directed toward diverse communities and cultures and toward the target population?

- Does the program promote bridges to the community? Does it participate in collaborative projects or have memoranda of understanding (MOUs) with other organizations addressing the same target population? Does it have a community advisory committee?

- Does the agency have a plan to address cultural competency? If such a plan is being developed, how well does the agency carry through on its implementation?

- Does the agency incorporate holidays celebrated by the target population into the activities of the agency?

- Do internal records promote cultural competency? For example, do assessment forms ask for client's language capabilities and preferences? Do questions about gender include transgender?

- Is there client involvement in policy and protocol making?

- Are there criteria to ensure cultural representation on the agency's board of directors? How is the board linked to the target population?

- How is the board responding to cultural competency and the changing demographics and needs of the agency's target population? Has the board adopted new policies regarding cultural competency?

Staffing Issues

- Does the program hire staff at all levels from the community being served?
- Are staff who reflect the community being served actively included in organizational management and leadership roles?
- Do staffing structures maximize the cultural and linguistic capabilities of staff?
- Are staff pay-scales at the level that they encourage people to apply for positions who identify with the target population ***and*** have the required skills?

Barriers to Assessing Cultural Competency

- It can't be done.
- It's subjective. It involves evaluating the intelligence and self awareness of staff, which is a complex undertaking. It cuts so many different way.
- It's based so heavily on self-reporting that you can only trust what people report up to a certain point.
- Everyone knows the answers you want to hear.
- Talking about cultural competency is a difficult, sensitive subject.
- You need to balance qualitative and quantitative data to assess cultural competency, and there will always be different opinions on how the achieve that balance.
- What some critics of the current allocation system are looking for is not so much an assessment of agency's cultural competency as they are demanding social justice. Assessing cultural competency will not address their belief that certain cultures are not receiving the they deserve.
- Some programs are so immersed in their work that they do not allot the time needed to adequately assess whether they are meeting the needs of their target community and whether their services are culturally competent.
- Program do not have the capacity or resources they need to do community needs assessments and program evaluations to determine and improve upon their cultural competency.

- Programs tend to run on cruise control until the funding runs out.

- For some people, HIV prevention is not as high a priority in their lives as other issues—shelter, immigration, feeding their family, etc.—so that that no matter how good the intervention, these individuals will alway remain very hard to reach. A program may not necessarily lack cultural competence if it is not able to reach these folks with the prevention message.

- How do you know if what an agency writes down on paper is real or not?

Cultural Competency Review Process

- You need to interview all stakeholders in the agency, not just its leadership, to assess cultural competency: member of the board of directors, management, staff, clients and other funders.

- Ensure that proposal reviewers embrace universal advocacy—having the ability to advocate for the rights and privileges and well being of the whole community, not just the communities to with which they personally identify.

- Proposal reviewers should be respectfully hesitant of the review process in all of its complexity.

- Assemble a pool of community evaluators to review proposals and provide them all with cultural competency training. Polaris has offered to provide this training.

- Create cultural competency standards to ensure that programs are evaluated with the same criteria.

- Issue a disclaimer with the cultural competency assessment as to the limitations of the assessment; for example, stating that the HPPC wants to establish minimum standards of cultural competency, but that it encourages programs to exceed these standards.

- The HPPC should receive cultural competency training before it addresses this issue. Polaris has offered to provide this training.

- Better than just assessing proposals would be to do site visits to agencies to observe the services actually being provided. Interview clients about the cultural competence of the provider.

- Make sure to pilot test your tool before making it public. Have the HPPC fill it out themselves to spot the dumb questions before you ask them of others.

Community Input

- Telephone surveys are good because people can schedule a time that is convenient for them.
- Mail surveys aren't the best because people don't want to sit down and fill it out. If you do mail a survey, reminder calls are helpful.
- The limitation of a Town Hall meeting is that people will be inclined to rehash all the old issues that we have all heard many times already. It may not be a constructive forum.
- A series of focus groups or informal discussion groups would be better than a town hall meeting. They need to be casual to promote a candid dialogue.

City and County of San Francisco

Department of Public Health
HIV Prevention Planning Council

MEMORANDUM

DATE: October 3, 1997

TO: HPPC

FROM: Assessment Committee

RE: Presentation at Council Meeting

The Assessment Committee was charged with the task of assessing and revising, if necessary, the Priority-setting model. At the Council Meeting on October 9, the Committee will make a presentation and ask for a concept vote to approve the direction it is taking with the revisions to the model.

In preparation for the meeting, we ask that you review the attached background materials -- a summary of Chapter 5 from the San Francisco HIV Prevention Plan. This is the model used last year to establish priorities, and it is what the committee assessed and is revising.

25 Van Ness Avenue, Suite 500, San Francisco, CA 94102 (415) 554-9000

Summary of priority-setting chapter of the 1997 San Francisco HIV prevention plan

CHAPTER 5 - PRIORITY-SETTING FOR BEHAVIORAL RISK GROUPS

RECOMMENDATIONS FOR PRIORITY-SETTING

The Priority-Setting Committee established a four phase process for prioritizing groups at risk. A summary of the four phases is presented below, followed by detailed information about each phase. In reading this information, it is important to bear in mind the Council's definition of "behavioral group" and "target group": **behavioral groups are defined according to behavior, rather than identity.** Examples of behavioral groups are men who have sex with men, women who have sex with men, and men who have sex with women and inject drugs. **Target groups are defined by identity, not necessarily sexual behavior.** A target group is defined by the prevention provider who intends to serve it; therefore, the group may be narrowly defined (such as African-American commercial sex workers) or broadly defined (such as injection drug users).

- **Phase I** prioritizes behavioral groups using a matrix that contains the estimated average annual frequency of risk activities and an estimated relative risk value for each activity.

- **Phase II** adjusts the Phase I score by including HIV prevalence and population size for each behavioral group. Phases I and II form the basic ranking of behavioral groups.

- **Phase III** identifies categories of co-factors, provides key examples for each, and describes them and their role in HIV transmission.

- **Phase IV** allows providers submitting applications for funding to apply the information in the Plan to their specific target groups, and requires providers to conduct a needs assessment of the primary risk factors and the co-factors in their target groups.

BEHAVIORAL RISK POPULATIONS IN PRIORITIZED ORDER

1. Males, transgender male-to-female (pre-operative), and transgender female-to-male (post-operative) who have sex with males and inject drugs.
2. Males, transgender male-to-female (pre-operative), and transgender female-to-male (post-operative) who have sex with males and females and inject drugs.
3. Males, transgender male-to-female (pre-operative), and transgender female-to-male (post-operative) who have sex with males.
4. Males, transgender male-to-female (pre-operative), and transgender female-to-male (post-operative) who have sex with males and females.
5. Females, transgender female-to-male (pre-operative), and transgender male-to-female (post-operative) who have sex with males and inject drugs.

6. Males, transgender male-to-female (pre-operative), and transgender female-to-male (post-operative) who have sex with females and inject drugs.
7. Females, transgender female-to-male (pre-operative), and transgender male-to-female (post-operative) who have sex with males and females and inject drugs.
8. Females, transgender female-to-male (pre-operative), and transgender male-to-female (post-operative) who have sex with females and inject drugs.
9. Females, transgender female-to-male (pre-operative), and transgender male-to-female (post-operative) who have sex with males and females.
10. Females, transgender female -to-male (pre-operative), and transgender male-to-female (post-operative) who have sex with males.
11. Males, transgender male-to-female (pre-operative), and transgender female-to-male (post-operative) who have sex with females.
12. Females, transgender female-to-male (pre-operative), and transgender male-to-female (post-operative) who have sex with females.

Using the abbreviations, the priority behavior groups are as follows (FTM= transgender female-to-male; MTF=transgender male-to-female; S=sex; M=male; F= female):

	Full abbreviation		Short abbreviation
1.	M; MTF (pre-op); FTM (post-op) - SM-IDU	OR	MSM-IDU
2.	M; MTF (pre-op); FTM (post-op) - SM/F-IDU	OR	MSM/F-IDU
3.	M; MTF (pre-op); FTM (post-op) - SM	OR	MSM
4.	M; MTF (pre-op); FTM (post-op) - SM/F	OR	MSM/F
5.	F; FTM (pre-op); MTF (post-op) - SM-IDU	OR	FSM-IDU
6.	M; MTF (pre-op); FTM (post-op) - SF-IDU	OR	MSF-IDU
7.	F; FTM (pre-op); MTF (post-op) - SF/M-IDU	OR	FSF/M-IDU
8.	F; FTM (pre-op); MTF (post-op) - SF-IDU	OR	FSF-IDU
9.	F; FTM (pre-op): MTF (post-op) - SF/M	OR	FSF/M
10.	F; FTM (pre-op); MTF (post-op) - SM	OR	FSM
11.	M; MTF (pre-op); FTM (post-op) - SF	OR	MSF
12.	F; FTM (pre-op); MTF (post-op) - SF	OR	FSF

The Priority-Setting Matrix is shown on the next page. The numbers from 12 to 0.001 on the first line refer to the relative risk of each of the acts listed: how much more risky is one act than another. The next "row" shows the acts that transmit HIV. Below each act are cells with two numbers for each behavioral risk population. The top number in each cell is the estimated average annual frequency that the behavioral risk population practices that act. The bottom number in each cell is the average annual frequency multiplied by the relative risk. For example, it is estimated that MSM-IDU in San Francisco practice sharing unsterile needles on average 70 times per year; this is multiplied by the relative risk factor of 12, for a total of 840 . The bottom numbers in each cell are added across to give the Phase I score on the right. Estimated prevalence, population size, and population score are listed. Phase I Score, Prevalence and Population Score are multiplied to give the Phase II score. These are put in rank order from highest score (1) to lowest score (12).

San Francisco HIV Prevention Planning Council
Priority-Setting Matrix

	Phase I															Phase II					
Relative Risk	12	9	3	2	2	1.5	1	1	0.5	0.5	0.1	0.1	0.1	0.002	0.001						
	Sharing Unsterile Needles	Anal Receptive Intercs	Vaginal Receptive Intercs	Anal Insertive Intercs	Vaginal Insertive Menses	Vaginal Insertive Intercs	Giving Fellatio	Giving Cunnlgs. Menses	Giving Cunnlgs	Other Blood to Blood	Getting Fellatio	Getting Cunnlgs	Sharing Unclean Sex Toys	Vag. to Vaginal Menses	Vaginal to Vaginal	Total Phase I	Prev	Pop. Size	Pop Score	Phase II Total	Rank
MSM-IDU	70 840	24 216		18 36			30 30			24 12	30 3		35 3.5			1141	64.71%	2,250	2	1,476.04	1
MSM/F-IDU	75 900	7 63		18 36	3 6	21 31.5	13 13	3 3	20 10	7 3.5	18 1.8		22 2.2			1070	48.53%	750	1	519.27	2
MSM		21 189		21 42			9 9			21 10.5	37 3.7		35 3.5			258	44.99%	41,250	3	347.82	3
MSM/F		21 189		21 42	3 6	21 31.5	9 9	3 3	20 10	21 10.5	37 3.7		22 2.2			307	33.45%	13,750	3	307.97	4
FSM-IDU	40 480	6 54	77 231				48 48			6 3		35 3.5	15 1.5			821	12.15%	3,300	2	199.50	5
MSF-IDU	38 456			6 12	12 24	82 123		6 6	41 20.5	2 1	42 4.2		22 2.2			649	13.96%	8,500	2	181.17	6
FSF/M-IDU	40 480	10 90	50 150				26 26	16 16	100 50	14 7		100 10	64 6.4	16 0.03	100 0.1	836	12.00%	625	1	100.26	7
FSF-IDU	40 480							14 14	94 47	12 6		94 9.4	124 12.4	14 0.03	94 0.094	569	4.35%	575	1	24.75	8
FSF/M		9 81	46 138				24 24	16 16	100 50	14 7		100 10	64 6.4	16 0.03	100 0.1	333	0.61%	15,750	3	6.09	9
FSM		6 54	62 186				33 33			6 3		37 3.7	15 1.5			281	0.19%	285,049	4	2.14	10
MSF				8 16	10 20	66 99		6 6	41 20.5	2 1	43 4.3		15 1.5			168	0.09%	252,544	4	0.61	11
FSF								14 14	94 47	12 6		94 9.4	124 12.4	14 0.03	94 0.094	89	0.08%	14,550	3	0.21	12

SUMMARY OF CO-FACTORS

The following is a brief summary of the co-factors. For a detailed presentation of co-factors, please see Chapter 3, Section IX.

STDs:

The presence of a genital STD increases risk for HIV. Other STDs may increase risk, and even a history of an STD is associated with increased risk or infection in many studies.

Poverty:

Poverty is associated with increased risk and infection, largely because of its connection with increased likelihood of substance use and commercial sex work. Perhaps, too, the poor nutrition concomitant with poverty may have a biological effect.

Homelessness:

Information about poverty applies to homelessness, as well. Additionally, incidents of forced sex, impaired mental health status, and debilitated health are issues of concern for members of this population.

History of Child Abuse:

A number of studies show an association between history of child abuse and HIV infection, due perhaps to a high prevalence of drug use, prostitution, multiple partners, and chronic depression.

Abusive Relationships:

Many in abusive relationships are survivors of childhood abuse, so the issues are similar, with the addition of a present threat of violence which makes condom negotiation less possible.

Rape:

Since rape occurs usually without condoms, some risk may exist; however, rape does not appear to be independently associated with HIV infection.

Social Support:

The association between social support and HIV is weak. It may be stronger among those of moderate or higher socioeconomic status, but has contradictory influences, or even negative influences, on risk for many vulnerable populations such as the poor, drug users, and homeless women.

Mental Health Stressors

Behaviors known to be associated with certain psychological disorders may increase risk of infection, including hypersexuality, poor impulse control, self-destructive behavior, impaired judgment, and substance use. Additionally, several studies have found an association between depression and involvement in high risk behaviors.

Substance Use/Abuse:

The association is not so much with general substance use or a history of substance use/abuse, but with substance use during sex. Crack and poppers have pronounced influences on risk.

Commercial Sex Work:

Commercial sex workers face considerable risk for HIV, due to high numbers of contacts, high prevalence of STDs, and high rates of substance use/abuse.

Multiple Partners/Risky Partners

People who have sex with multiple partners may be at greater risk for HIV infection than those who have sex with a single partner because the probability of contact with an infected individual increases as the number of partners increases. Persons with risky partners also may be at increased risk for HIV if protection is not consistently used. Some people may assume that they are not at risk, not knowing that their partners are engaging in high-risk activities.

Lack of Access:

Knowledge of services and prevention services in a language and manner suitable to the audience are fundamental to effective prevention, although, strictly speaking, no studies were found to show a statistical association.

Incarceration:

High rates of HIV seropositivity among people entering the criminal justice system pose a threat of infection through unsafe sexual and injection drug use practices to others who are incarcerated.

Low Perception of Risk:

Perception of risk for HIV is a necessary precursor for risk reduction behaviors.

Discrimination:

Because of its complex nature, little is known of the statistical association of discrimination and HIV risk, but these issues are critical considerations in the provision of prevention information.

DEFINITION OF CO-VARIATES AND CO-FACTORS

The HPPC uses the terms co-variates and co-factors in discussing the priority-setting model. A co-variate is a term to describe the characteristics of a population, specifically ethnicity, age group, and neighborhood. Co-variates in themselves do not increase the risk for HIV. A co-factor is a factor that either increases risk for HIV transmission or increases the susceptibility to HIV if exposed. Examples of co-factors are listed above.

Target groups (identified by providers) can be described in terms of co-variates, co-factors, and behavioral risk behaviors. The following are examples of target groups showing which elements are co-factors, co-variates, and BRP:

African-American co-variate	young co-variate	MSM BRP
Native American co-variate	women co-variate	of childbearing age co-variate
Homeless co-factor	adults co-variate	
Commercial sex workers co-factor		

HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for October 9, 1997

* Please note in your calendar any of the following meeting times that apply to you: *

HPPC:	Thurs., Oct. 23, 3-5 p.m. at the First Unitarian Church
	Thurs., Nov. 13, 3-6 p.m. at the First Unitarian Church
Linkages Committee:	Mon., Oct. 20, 3-5 p.m. at the AIDS Office
Assessment Committee:	Thurs., Oct. 30, 1-3 p.m. at the AIDS Office
Evaluation Committee:	Thurs., Oct. 23, 5-6:30 p.m. at the First Unitarian Church

Members Present:
Ronnie (Chata) Ashley
Marcos Bañales
Elizabeth Davis
Ellen Goldstein
Liz Highleyman
Valerie Kegebein
Sacul L'Adnbre
Sonja Mackenzie
Askia Muhammad
Jimmie Naritomi
John Newmeyer
Henry Ocampo
Tracey Packer
Colin Partridge
Dawn Passar
María Rinaldi
Bethsaida Ruiz
John Blake West
Thomas Zickgraf

Members Absent:
Barbara Adler
Michael Discepola
Brenda Escobar
Kevin Gogin
Jelousy Jiggetts
Joel Reyna
Steven Sams
Sandy Simms

Leave of Absence
Jennifer Lorvick

HPPC Process Evaluation Team:
Pali Basi
Raquelle Caras
Cely Queiroz
Kathleen Roe
Kevin Roe

Guests:
Bernard Henderson, BCA
Julie, SFSU Student
Shelly, SFSU Student
Christopher Smith, New Village
Stacy Vogan, STD/HIV Prevention Training Ctr.
Hank Wilson, ACT UP Golden Gate

Harder + Co./Polaris, Inc.:
Amalia Fernandez-Niewendorp, Polaris, Inc.
Rick Green, Harder + Co.
Lyn Paleo, Harder + Co.

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1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Tracey convened the meeting shortly after 3:00 p.m. She asked that members and guests introduce themselves. She welcomed everyone and asked if there were any announcements.

Announcements

Henry Ocampo

- Informed the Council that he would be on vacation throughout November, returning to San Francisco on December 1.

Ellen Goldstein

- Distributed the "HPPC progress report" that had been published in the October 2, 1997 Bay Area Reporter. Chata added that any comments or feedback be forwarded to Tracey at the AO.

John Blake West

- Provided a brief update on the 7th Annual Pre-Folsom Street Fair Brunch. The brunch successfully raised $3,000 that will benefit the AIDS Emergency Fund.

Maria Rinaldi

- Notified the Council of the Immigrant Pride Day, scheduled for Sunday October 19 from 10 a.m. to 5 p.m. at 24th and Mission Street.

Tracey Packer

- Informed the Council that James Rapues had resigned from the Council. He has also resigned from the Linkages Committee and his position at LYRIC. He is re-locating to San Mateo County and is looking forward to continuing his efforts in HIV prevention.

Member Absences

- Ellen stated that Barbara A., Mike D., and Steven S., had all called to inform the co-chairs of their absence from today's meeting. They were preparing for the AIDS Health Project's Gala Night. Tracey added that Mike had also contacted her and requested that she extend his apologies and support to Sacul and Maria during their presentations. Tracey also informed the Council that Joel R. had called to inform her of his absence from today's meeting. (Joel also forwarded his specific comments pertaining to the Assessment Committee presentation.)

2. PUBLIC COMMENT

Tracey introduced this agenda item by reviewing the rules for public comment. Tracey introduced speaker *Hank Wilson of ACT UP Golden Gate.*

- Hank began by distributing a recent article from the October 2, 1997 Bay Area Reporter, *"Non-compliance a factor in UCSF study showing 53% failure of protease therapy,."* by Cynthia Laird. He indicated that similar articles in the San Francisco Chronicle and Examiner did not make mention of the 'non-compliance.' He noted that this is a very important part of the puzzle, especially for those who are participating in that type of therapy. It was very disturbing to read the Chronicle and Examiner articles, knowing they were not reporting all of the information. He added that the public needs to understand that compliance is a hard and difficult task. He also noted that this specific information could prove to be useful in prevention counseling.

- Hank referred to another recent article "Gays Raising Gonorrhea Rates Spur HIV Fear." The article was based on information released by the Centers for Disease Control and Prevention. He pointed out that the editorial notes stated "...although complete data were unavailable, preliminary observations from Portland, San Francisco, and Seattle have linked Gonorrhea cases in MSM with attendance at certain local clubs and other places frequented by MSM. Observations from Seattle further implicated sexual activities with anonymous partners and the use of illicit drugs and alcohol. San Francisco stood out as one of the cities with an upward trend." Hank summarized that the article did little to provide pertinent information that could be utilized by prevention providers working in the community. He specifically made mention of the incomplete data and the lack of specificity pertaining to the actual clubs and the types of illicit drugs. He noted that he is not interested in reading about individuals attending sex clubs as part of the media story -- unless the story provides **all** of the information. It is intolerable to publish limited information that only admonishes the right wing in their attacks on our community. He stated that the CDC has a responsibility to those communities that cooperate with them regularly, to provide them with the most complete information available.

- Hank referred to the issue of HIV name reporting which is currently being considered at the CDC. If initiated it will mandate that all individuals who test HIV positive, have their names reported to state and local Departments of Health and aggregate numbers reported to CDC. The mandate would apply to all clinics, doctor offices, and any locations where HIV testing is administered. He expressed his concern pertaining to the repercussions this type of mandate could have on prevention efforts. He added that even though it seems that a decision will favor initiating something along these lines, the

community should voice its concerns to the President. Currently the decision is being held up due to a few voices that have spoken up. He stated that, "We don't need to hear the same predictable voices, we need to hear feedback from the community grass roots providers. There is a need to communicate the consequences this type of mandate will have on our prevention efforts." The CDC Director is a presidential appointee, therefore one word from the White House could slow or even stop this process. Lastly, he stated that currently we are dealing with a "friendly administration," but what should happen if we have mandated name reporting in an "unfriendly administration"?

HPPC Response to Public Comment
Ellen asked whether Hank had specific information pertaining to the Gonorrhea study -- the author, who sponsored it and the publication name. Hank informed the Council that he had found the information at the UCSF library. He indicated that since San Francisco was referenced in this study that was published in an article, the DPH/AO should have made this information available to the Council members.

Tracey indicated that Stacy was distributing copies of the CDC Morbidity and Mortality Weekly Report (MMWR) dated September 26, 1997. The report included an article of the upward trends of Gonorrhea.

Jimmie stated that the media consistently reports what they feel is newsworthy. With this in mind he was concerned that the public comment might have been too harsh on the CDC. It is conceivable that the CDC reported fully and the media chose not to include all of the information. Hank indicated that this could have been the case, however this type of situation is unacceptable.

3. REVIEW AND APPROVAL OF 9/11 AND 9/25 MINUTES

Tracey informed the Council that there was a quorum present to approve the minutes. She informed the Council that the September 25 minutes had not yet been distributed; therefore their approval would be postponed till the October 23 meeting. She then asked if there were any comments, revisions or questions for the September 11 minutes. There were none. A motion and a second were made to approve the September 11 minutes. With a quorum present, the September 11 meeting minutes were approved, with one abstention.

4. LINKAGES COMMITTEE - PROGRESS REPORT

Tracey introduced the Linkages Committee for their presentation. She indicated that based on the information that was distributed with the meeting agenda, she feels the Committee has been doing extraordinary work. She then introduced Sacul, the Chair of the Committee.

Sacul began by introducing the Committee members: Chata, Marcos, Hector, Sonja, and Dawn. She also introduced Ruel and Pali, from the Process Evaluation Team, Rick from Harder + Co. (who replaced Ellen Irie) and Delia, from the AO. She thanked all of the members and individuals who contributed to the Committee's work.

Sacul explained that during the last RFP process the HPPC had identified a gap pertaining to the issue of cultural competency within the RFPs. The Council assigned the Linkages Committee with the task of reviewing cultural competency information available in order to develop a tool that could be used in conjunction with the RFPs to facilitate the assessment of an organization's cultural competency. The Committee reviewed a variety of materials that had been developed by various organizations to address cultural competency. (*Sacul indicated that the Committee had favored the California Office of Multicultural Health information the most.*)

The Committee then set out to develop a set of Guiding Principles for Cultural Competency. Since the principles were at the heart of the Committee's work, the members agreed to seek community input pertaining to the definition of cultural competency. The Committee enlisted the assistance of Ellen I., of Harder + Co. to create and conduct a series of Key Informant Interviews. Once the interviews had been completed, Ellen I. summarized the results in the "Key Informant Interview Findings" dated September 8, 1997. The Committee then utilized the input from the interviews to add to the Guiding Principles. Lastly, the Committee faced the task of determining which of the guiding principles could be modified into questions for the Cultural Competency Tool. Sacul then introduced Sonja for the next part of the presentation.

Sonja informed the Council that she would be reiterating the process previously discussed by Sacul and elaborating on some of the key points. She stated that once the Committee completed the review of the cultural competency information they were able to develop the Guiding principles. The Committee discussed each of the principles extensively and determined that there were two distinct categories: Overarching and Agency Specific. The overarching principles -- eleven -- were philosophical in nature and difficult to measure. The agency specific principles -- fourteen -- were somewhat easier to measure and became the foundation of the cultural competency tool questions.

Sonja indicated that during the development of the principles, the Committee members expressed their desire to include the broader community in the discussion, hence the key informant interviews. She stated that when the results from the eleven key informant interviews were analyzed, there was a clear indication that the Committee was on the right track. In addition to the 'vote of confidence' the broader community provided for the Committee, the specific community input also furnished the Committee with useful ideas they had not yet considered. The Committee utilized this community feedback along with all of the materials the Committee had reviewed and developed to create the draft cultural competency tool. The draft questions were derived from the agency specific principles. Sonja introduced Thomas for the next part of the presentation.

Thomas distributed the draft tool that has been developed by the Linkages Committee. He explained that the Committee had agreed upon a specific process to refine the draft tool. That process included distributing the draft tool throughout the community with the intent of soliciting specific feedback that could indicate whether the questions were reasonable and/or whether the Committee was asking the right questions. Once the feedback has been received and incorporated, the Committee will present the final cultural competency tool to the full Council. On behalf of the Linkages Committee, Thomas encouraged Council members to express their feedback -- preferably in writing -- to the Committee.

Chata summarized the Committee's next steps. The Committee will disseminate the draft tool to: Council members, the Organizational Development and Technical Assistance Project, CARE Providers, and Prevention Providers throughout the City of San Francisco. Chata reiterated that once **all** of the feedback has been received and incorporated, the Committee will present the results to the full Council. Next, the Committee will begin reviewing the contents of the RFP to determine the extent of cultural competency information within that application. The Committee will also have to decide the manner in which they will incorporate the cultural competency tool into the RFP.

Sacul thanked her co-presenters, all of the Linkages Committee members, including Delia. She also extended a special thanks to Rick for all of his excellent work. She then requested that Council members feel free to ask any questions or express any comments that they might have.

COUNCIL RESPONSE TO THE LINKAGES PRESENTATION

Jimmie acknowledge the difficulty of this task and expressed his gratitude to the Committee for all of their work. He stated that the issue of cultural competency is a very broad and complicated subject. He referred to the draft tool, page two, question four. He pointed out that there is a lack of cultural competency trainings in existence, particularly for specific sub-groups. He expressed his concern that it would be difficult to develop an adequate assessment of cultural competency trainings when they may not exist.

Liz recommended that an additional box be included that would enable the agency to provide a brief description of the training. (Such as what culture did the training target, what were the specifics of the training, etc.) She admitted that this would require some subjectivity from the reviewer, however it would reflect a clearer picture of the training.

John W. agreed with the comments expressed by Jimmie and Liz. He indicated that the quality of the training was an important factor that was not being addressed in this question. He recommended the inclusion of a qualitative aspect, such as the credentials of the trainers. He clarified 'credentials' as not necessarily academic credentials, but rather, the special characteristics or knowledge the trainer(s) possessed.

John N. indicated two concerns. First the lack of space available for agencies to respond and second, the tool's open-ended quality -- which could become problematic during the review process.

Maria stated that her concern was not necessarily with the concept of the tool, but rather with its implementation. She indicated that many times the concept is sound, but it is difficult to implement. Another concern Maria indicated was the issue of cultural competency trainings. She expressed her support for cultural competency trainings to all agencies. However, it would be difficult to say that just because an agency hires an individual from the community to provide cultural competency training, that that individual is the most able trainer or that the training actually enables the agency to be culturally competent. This would also be the case with 'in-house' trainings. Maria also expressed her regret and aggravation with the fact that eight Council members were absent today.

Chata thanked Council members for their feedback. He explained that as a Committee, Linkages members had debated many of the same issues. He also added that it would be impossible for anyone to be completely culturally competent even within their own community. He stated that the overall mission was to develop a tool that indicated some sense of an agency's understanding of its target population. He stated that the Committee welcomes the Council's feedback pertaining to the types of questions that might better reflect an agency's cultural competency.

Sacul expressed her agreement and added that the Committee felt overwhelmed with this task on more than one occasion. However, she added that the Committee followed through with the process and they feel this draft is a good foundation. She also noted her disappointment at the number of absences.

Colin expressed his support of the presentation and the document created by the Linkages Committee. He noted that the tool addresses the important issues of who is being served and who is providing the services. However, he suggested that the Committee consider adding some questions about how clients evaluate the agency's cultural competency and how the agency actually implements cultural competency.

Henry stated that he was very impressed with the Committee's efforts. He indicated that his primary concern when it comes to cultural competency is the way it is implemented.

Tracey suggested that to get a place of reference for the agency's cultural competency, the Committee might consider asking a question about how the agency defines cultural competency. She then referred to the previous comments about cultural competency trainings. Although the comments and issues discussed are important factors, it is her experience that cultural competency trainings do not have to be culture specific. The trainings can be about different methods that can be utilized for an agency to become more culturally competent.

Ellen indicated that she had learned a lot by reading this document. She stated that once agencies begin to discuss and respond to this tool, it will begin to serve as a statement of priority. She expressed her satisfaction that this tool would be included in the RFP process and suggested that it also be considered as part of the monitoring process. She noted that the tool supersedes its initial intent by also serving as an educational tool that will get people and agencies closer to the goal of becoming culturally competent. She stated that she liked the idea of dividing the questions into indicators, i.e. organizational competency, programmatic competency. She suggested that the tool be organized with those headings (taken from the summary of materials provided by the committee.) Lastly, she noted that she was appreciative of the expansion beyond race and ethnicity.

John N. noted three methods that had been utilized to assess HAFCI cultural competency. The first method asked what number of the board/staff were gay men -- specifying sexual orientation. He considered this method as the most inadequate. The second method was similar to this tool in size, but asked more specific information about gay male issues. Unfortunately, the staff began forwarding the questions to the gay male staff. The last and most effective method was a study conducted by Ed Morales, who evaluated the cultural competency of agencies by asking their clients. He suggested that the Committee consider a process such as the last method used by Ed Morales.

Linkages members noted that there were a few questions -- 5, 6, and 7 -- that attempted to derive some information about the client participation. Members discussed and agreed that although the tool asked for specific input about the clients, the agencies would be the ones responding to the questions, not the clients. Ellen summarized that the suggestion was to consider an external evaluation process.

John W. referred to the training questions of the tool. He indicated that cultural competency training is not a singular event; it should be a continual effort within the agency. Therefore, he suggested that the Committee also consider including a question pertaining to the number of times the trainings were offered. Secondly, he requested some assurance from the DPH/AO staff that during the monitoring process some attempt be made to address the issue of cultural competency. Tracey responded that the DPH/AO would certainly take the recommendation and attempt to implement it as much as possible. She also suggested that if time allowed, the Linkages Committee could also attempt to develop ways that the tool could be incorporated into the monitoring protocol.

Jimmie referred to page six, number eleven. He pointed out that if the agency was a singular entity, providing HIV prevention services only, then the questions would be relevant. However, if the agency is a multi-service agency with many collaboratives, then the task becomes overwhelming and would not serve the intended purpose. Marcos responded that the tool was only addressing the HIV prevention program or agency. He added that participating in this Committee had been a learning experience for him, since many of the issues discussed were new to him. In reference to comments that the tool might be too long, he stated that if an agency claims to be providing services to a diverse population, then they need to take the time to complete the tool. He indicated that this will be something very 'new' to many providers, but it is something that needs to be addressed.

Chata agreed and noted that as the Committee begins to review the RFP -- to determine the extent of culturally competent content -- they will be faced with the task of deciding how much they will be allowed to ask of providers. The Committee will eventually have to determine how to balance the cultural competency information with the existing RFP information. Maria noted that she would rather see more questions than less to assure that providers are actually providing culturally competent services.

Dawn stated that her intent while participating in this Committee was to include the sub-populations that usually fall through the cracks. She added that if agencies are not culturally competent, then they need to become aware of that.

Askia expressed his support of the tool and indicated that as a service provider he is interested in seeing how it will be implemented. He stated that many times providers are working with clients whom they believe are similar to them; however with the multitude of factors within each culture, that may not be the case. He indicated that he felt it is very important to ask the clients for their feedback as well.

Sacul again thanked all of the individuals who have participated in the Committee and the Council for their feedback and support. She indicated that any feedback may be forwarded to Rick Green at Harder + Co. - fax number 415-522-5445. The deadline for feedback is October 30, 1997. On behalf of the Council, Tracey thanked Sacul and the Linkages Committee for their outstanding work. She asked that members complete the evaluation of the Linkages presentation

5. ASSESSMENT COMMITTEE - CONCEPT VOTE

Tracey introduced Maria, Chair of the Assessment Committee. Maria began by introducing the Committee members: Christopher Smith, John W., Jimmie, Askia, Joel, Valerie, Tracey, Mike, Lyn Paleo, Kevin Roe, Pali Basi, and Emily Coles. (*Maria also commended Chris for his dedication to the Committee which is reflected in his almost perfect attendance record.*)

Maria began by summarizing two of the objectives stipulated in the HIV Prevention Plan.

1. By 5/31/97, evaluate the RFP process from 1996 and make written recommendations to the AIDS Office for improvements.
2. By 7/31/97, review the 1996 priority-setting process and recommend changes accordingly to the AIDS Office and to the HPPC.

She explained that the Assessment Committee tasks were a result of these two objectives. Based on these reviews, she stated that the Committee has not yet completed the first task of reviewing the RFP process. She indicated that the presentation would be covering the second task that the Committee has been focusing on.

Maria explained that the Committee began by identifying some main concerns about the priority-setting model. Some of the concerns included:

1. The model relies heavily on prevalence.
2. The model does not include sub-populations that are highly impacted by co-factors in the ranking. *(She referred to the recent Supplemental Funding, that specified not just the BRP, but rather specific sub-population within the BRP. Maria gave the example of 'Latino immigrant homeless' as a specific sub-population.)*

3. The matrix mixes quantitative measures (prevalence) with qualitative measures (population size scale). *She summarized that the current Matrix does not provide the actual number of people within a population, but rather uses a scale to represent population size.*
4. Some applicants have to write up a behavioral risk score that results in an additional burden on the providers.
5. The minimum score is used as an eligibility criterion. *She summarized that for RFP 015, applicants needed to have a score of at least 100 to be considered.*

Maria indicated that for each of the five concerns, the Committee discussed and came up with options that could possibly rectify the situation. First, the Committee agreed that HIV prevention needed to be specific to both HIV positive and HIV negative persons. The members discussed the need to return to the primary goal of prevention -- which is to avoid new infections. She stated that it soon became apparent that the message needed to be directed to both populations.

Maria then referred to an overhead depicting the current priority-setting model and the proposed priority-setting model. Both models stipulate the use of the BRPs. However, the current Matrix includes: frequency of behaviors and relative risk of each behavior, prevalence, and the population size score. The recommended Matrix would include just incidence and prevalence. She indicated that the Committee has yet to determine how this recommendation would be implemented, but members have discussed using the variety of information that is available, such as the Consensus meeting data. She stated that this proposed Matrix would simplify the entire priority-setting process and reflect the reality, which is both prevalence and incidence.

She stated that the current model does not include the sub-populations at especially high risk within lower ranked BRPs (highly impacted by co-factors) in the Matrix. The proposed Model would include these sub-populations by identifying them within each of the BRP's that are in the Matrix. She explained that the Committee had discussed the fact that if someone was to address BRP10 -- WSM -- the Matrix only lists the average for all women who have sex with men. The problem with this is that not all of them will have the average risk, some will have less risk and others will have greater risk due to the effect of co-factors. With that in mind, the Committee agreed on the need to identify the sub-populations that were at greatest risk within all of the BRPs.

Maria indicated that one of the lessons learned from the last RFP process was that the broader community felt they did not have the opportunity to provide input pertaining to the priority-setting model process. The Committee discussed and agreed on the need to include the broader community by inviting them to an open meeting -- or two -- to express their opinions on the proposed revisions. After that meeting the Committee would incorporate what was possible and then present the final product to the Council for review and a final vote. Maria introduced Chris for the proposed HPPC's Guidance for Prevention Funding.

Chris stated that the following were the guidance/principles that the Committee would like the HPPC to adopt as recommendations to the AO.

1. Allocate funds for prevention among both HIV positive and HIV negative persons
2. Some funding to each of the BRPs
3. Higher-ranked BRPs should receive more resources than lower-ranked BRPs
4. The 'X' highest ranked BRPs should be allocated no less than 'Y'% of funds. (Example: the 3 highest groups no less than 50% of funds or the 7 highest groups no less than 70% of funds.)
5. Sub-populations identified by the HPPC should be ensured funding, through whatever mechanism works best

Maria then introduced John W. for the proposed HPPC's Recommendations for Proposal Review. John explained that the Committee had recognized the different roles and responsibilities existing in the RFP process. The HPPC's role is not the decision making role in how the process is implemented; however the Committee attempted to delineate several areas that they felt the HPPC should be able to advise the AO in formulating the Process to assure that RFP responses are reviewed in an appropriate manner.

John stated that the Committee had agreed to propose the following recommendations.

1. At least two HPPC members review draft RFP for alignment with HPPC recommendations.
2. HPPC collaborate with the AO in trainings for providers prior to the application.
3. Recommendations will be made about technical review panels (in progress).
4. Keep eligibility criteria very basic (address BRP; be in SF; get application in on time).
5. Eligibility criteria does not include a minimum risk score (or other technical restrictions).
6. Tell applicants the basis for decisions (Section C).
7. Applications should respond to all the recommendations of the HPPC - linkages; strategic evaluation; strategies and interventions, etc.

Maria invited other Committee members to make any additional comments. On behalf of the Committee, Jimmie apologized to the Council for not distributing the presentation materials sooner. He indicated that the information had not been finalized with enough time for the Committee to mail the information out.

COUNCIL RESPONSE TO THE ASSESSMENT PRESENTATION

Colin expressed his approval of simplifying the Matrix. He also requested clarification as to why the Committee had proposed to delete the population size. Jimmie responded that for population size, the Matrix combined quantitative and qualitative data. The Committee's biggest hurdle was the issue of co-factors and how they could be included. After many discussions, the Committee agreed that there was no way of quantifying the co-factors -- ranking one higher than another -- therefore they deleted that section of the Matrix. Colin noted that the other change which he felt was important was the change from a threshold to a proportional system. John added that the Committee had not been able to come to a conclusion as to what formula could be created to consider incidence and prevalence together. The Committee also needs to consider how population size may be addressed. The Committee is hoping to solicit the expert advise of the epidemiologist of the AO, on how best to address that.

Chata indicated his concern that the guidance for prevention seemed to be moving towards categorical funding. Tracey responded that the proposed guidance was different than categorical funding because it was focused on ensuring a certain percentage of funding for the highest ranked BRPs. Hypothetically speaking, it could look something like: 50% of funds go to BRP 1 through 5, 20% go to BRP 6 and 8, etc. The primary difference between this and categorical funding is that this is not about services but rather about funding levels for populations.

Maria added that these aspects are strictly 'recommendations' to the AO. The HPPC would have no final or binding authority, the HPPC has purview only in the priority-setting.

Ellen expressed her approval of the Committee's work. She specifically approves of recommending percentages of funding for the BRPs which she feels is the strength of prioritizing and combating HIV. However, she asked for clarification about the fact that it seemed the Committee would be using a combination of quantitative and qualitative data with the proposed Matrix by combining prevalence and incidence data with prioritized sub-populations. She also asked for clarification as to how the Committee

thought they might determine the prioritization of sub-populations within the BRP. Maria admitted that the Committee had not been able to determine the actual methods they would be recommending; that will be part of the next step for the Committee. However, she did responded to the first part of Ellen's question by indicating that the Committee was not criticizing the use of qualitative and quantitative elements; they were concerned as to where they were used in the Model. The proposed Matrix is based on prevalence and incidence, and the co-factors are left outside of the Matrix. Currently co-factors are to be addressed by the providers. The proposed recommendations are different in that they are attempting to utilize co-factors through identifying sub-populations.

John W. stated that the Committee's concern was the defensibility of the Model. It seems that the qualitative elements (co-factors and the sub-populations) should be considered at the appropriate part of the process -- perhaps as simple set asides. He indicated that the Committee wants to recommend that the AO meet the needs of the sub-populations that have been identified as priorities, if the RFP process does not satisfy those needs. He added that the Committee has not come to any conclusions as to how this could be done.

Liz expressed her approval of the proposed Matrix and asked whether the actual behaviors would be considered anywhere else in the model. Maria responded that the Committee had agreed to continue working with the 12 BRPs, however, they did discuss the possibility of revising the BRPs. She gave the following example. In the BRP- MSM/F, one man could identify as being heterosexual, yet occasionally has sex with men. Another man, might identify as being gay, yet occasionally has sex with women. Both these men fall into the BRP MSM/F, however, they do not share the same level of risk. Maria indicated that this example is a clear indication that the BRP needs to be reviewed.

Liz reiterated her request for clarification pertaining to the actual behaviors, and whether there would be a way to distinguish between, for example, MSM who have unprotected anal receptive sex and MSM who have unprotected oral sex. Chris responded that one of the things the Committee intended to do was to establish a structure that freed programs to be innovative. The Committee wanted to develop a framework that would allow programs responding to proposals the ability to articulate what, how and the logic behind what they were indicating they were going to do.

Sacul stated that she was happy to see the changes to the Matrix.

Tracey indicated that Joel (a Committee member), had faxed a copy of his comments and concerns. He asked that they be presented to the Council during today's discussion. She indicated that anyone interested in seeing his specific fax could request copies from Maria. She summarized that Joel's primary concern pertained to the sub-populations. He was concerned about the sub-populations getting funded, as well as the method that would be used to rank the sub-populations within each of the ranked BRPs. He also noted the possibility of receiving no applications for a specific sub-population. If that scenario was to occur, how would the AO address that issue? Would money be set aside for an additional RFP or sole sourcing, and if that was the case, would that hold up services for the specific sub-population? Tracey indicated that the Committee had not yet been able to discuss this last issue. However, she indicated that the RFPs are always processed far in advance of the funding year, so as to begin funding the following year. It is very important to the AO that none of the funding be held up for any of the populations. She assured the Council that the Committee will continue to discuss the issue of sub-populations.

Ellen moved that the Council accept in concept the progress of the Assessment Committee and the direction in which they are moving. There was a second. Tracey facilitated the vote and summarized that the motion was to accept in concept the direction that the Assessment Committee was moving and support their

continued work in that direction. The Council was unanimously in favor of the direction the Assessment Committee has taken.

Maria thanked everyone on the Committee and extended a special thanks to John W. who has put so much energy into this process.

7. CLOSURE/EVALUATION

Ellen thanked everyone and asked that members complete their evaluation forms before leaving. She gave a brief summary of the agenda for the next Council meeting. She stated that the Council would be discussing and voting on the Membership Committee's proposed revisions to both Proxy Voting and the Public Comment Protocol. The Council would also be briefly discussing the Roles and Responsibilities (R&R) document. She indicated that the last time the R&R document was discussed, Council members agreed to forward any comments or revisions to the R&R Task Force. As of today, the Task Force has not received any comments or revisions. Lastly, Ellen stated that the Mayor's Summit on AIDS had been re-scheduled for January 27 and the Summit's Prevention Committee will be presenting at the next Council meeting.

Attached to these minutes for absent members:

- Bay Area Reporter, October 2, 1997 article, "HPPC Progress Report."
- Bay Area Reporter, October 2, 1997 article, "Non-compliance a factor in UCSF study showing 53% failure of protcase therapy."
- CDC Morbidity and Mortality Weekly Report, September 26, 1997/Vol. 46/No.38.
- Cultural Competency Assessment Tool, Draft Questions. (*Second draft dated 9/26/97*)
- Assessment Committee's Draft Priority-Setting Recommendations, 1998. *(Dated 10/07/97)*
- "Process Evaluation Results" and "Participant Dialogue" box from the September 25 meeting.

Minutes Recorded by: Amalia Fernandez-Niewendorp, Polaris R & D, Inc.
Minutes Approved by: Ellen Goldstein, Co-Chair and Tracey packer, AO Co-Chair.

HIV PREVENTION PLANNING COUNCIL MEETING

OCTOBER 23, 1997
3:00 PM to 5:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer

REVISED AGENDA

1. Food/Welcome/Introductions/Announcements	Chata	3:00 - 3:10 PM
2. Review and Approval of 9/25 & 10/9 Minutes	Chata	3:10 - 3:15 PM
3. Membership Committee (Proxy Voting discussion and ByLaws Change) **Vote**	Jelousy Jiggetts	3:15 - 4:05 PM
4. Presentation and Discussion on the Mayor's AIDS Summit	Ellen Goldstein	4:05 - 4:55 PM
5. Closure/Evaluation	Tracey Packer	4:55 - 5:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC Meeting - Thursday, **November 13, 1997, 3-6** PM, First Unitarian Church 1187 Franklin Street (@ Geary)

HPPC Meeting - Thursday, **November 20, 1997, 3-5** PM, First Unitarian Church 1187 Franklin Street (@ Geary)

Note: The two November meetings are one-week apart because of the Thanksgiving holiday!

DPH

DOCUMENTS DEPT.

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HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for October 23, 1997

* Please note in your calendar any of the following meeting times that apply to you: *

HPPC:	Thurs., Nov. 13, 3-6 p.m. at the First Unitarian Church
	Thurs., Nov. 20, 3-5 p.m. at the First Unitarian Church
Linkages Committee:	Tues., Nov. 4, 12-2 p.m. at the AIDS Office
	Mon., Nov. 10, 3-5 p.m. at the AIDS Office
	Mon., Nov. 24, 12-2 p.m. at the AIDS Office
Assessment Committee:	Fri., Nov. 14, 1:30-2:30 p.m. at the AIDS Office
Evaluation Committee:	Fri., Nov. 7, 4-6 p.m. at the AIDS Office
New Member Orientation:	Fri., Nov. 7, 9-11 a.m. at the AIDS Office
	Thurs., Dec. 4, 3-5 p.m. at the AIDS Office

Members Present:
Barbara Adler
Ronnie (Chata) Ashley
Marcos Bañales
Elizabeth Davis
Michael Discepola
Brenda Escobar
Ellen Goldstein
Liz Highleyman
Jelousy Jiggetts
Valerie Kegebein
Sacul L'Adnbre
Sonja Mackenzie
Askia Muhammad
Jimmie Naritomi
Tracey Packer
Colin Partridge
Dawn Passar
Steven Sams
John Blake West

Members Absent:
Kevin Gogin
Dave Hubbard
John Newmeyer
Henry Ocampo
María Rinaldi
Bethsaida Ruiz
Thomas Zickgraf

Leave of Absence
Jennifer Lorvick

AIDS Office Staff:
Barry Brinkley
Brian Dobrow
Delia Garcia
Mike Pendo

Guests:
Shelly Chen, SFSU
Ramona Holloway, SFBCA
Julie Ginsburg, SFSU
Stacy Vogan, STD/HIV Prevention Training Ctr.
Hank Wilson, ACT UP Golden Gate

Harder + Co./Polaris, Inc.:
Amalia Fernandez-Niewendorp, Polaris, Inc.
Martin Forst, Polaris, Inc.
Rick Green, Harder + Co.

HPPC Process Evaluation Team:
Ruel Caneda
Pali Basi
Kathleen Roe
Kevin Roe

1. FOOD/WELCOME/INTRODUCTIONS/ANNOUNCEMENTS

Chata convened the meeting shortly after 3:00 p.m. He asked that members and guests introduce themselves. He welcomed everyone and asked if there were any announcements.

Announcements

Sacul L'Adnbre

- She reminded Council members of the October 31 deadline for feedback on the Linkages Committee's Cultural Competency Tool Draft. She asked that all feedback be forwarded to Rick Green, at Harder + Co. (415-522-5400 or fax 415-522-5445).

Kevin Roe

- He indicated that he would be filling in for Kathleen, who was unable to attend today's meeting due to a family medical problem.

Dawn Passar

- She notified the Council of the Hooker's Ball, on October 31 at the Mary Town Hall. Tickets are available at the door or through BASS.

Tracey Packer

- She indicated that the October 9 HPPC meeting minutes were available for members at the back table. She stated that they will be approved at the November 13 meeting.

- She welcomed Barry Brinkley, the new AO Director of HIV Prevention. She summarized that he comes to the AO from Alameda County with experience on planning, both prevention and CARE Councils. She indicated that the prevention team is excited about working with him and is looking forward to his relationship with the HPPC.

- She informed the Council that Mobilization Against AIDS International is seeking individuals to participate in the proposals review committee that will determine the benefiting organizations of the 1998 San Francisco AIDS Dance-A-Thon. Loras Ojeda, Community Relations Director for Mobilization against AIDS, extended an invitation to all Council members. She distributed copies of the invitation letter from Mr. Ojeda.

- She reported that the AO is soliciting nominations for the community co-chair position currently held by Chata, whose two year term ends on December 31, 1997. The by-laws require that nominees serve on the Council for one year prior to their appointment as a co-chair and that there is gender and racial parity. Five current members are eligible for nomination.

  - ◊ Chata
  - ◊ Jelousy
  - ◊ Askia
  - ◊ Jimmie
  - ◊ Henry

  Tracey indicated that not everyone on the list has been contacted, therefore there might be some who are eligible but not interested. Askia requested that his name be removed from the list of candidates. Tracey clarified that each member could submit one nomination from the list of possible nominees. Members wrote their nominations on slips of paper and then forwarded them to Brian. Tracey added that nominations would be accepted throughout the course of today's meeting. She explained that once the nominations have been made the nominees will notified. Although a timeline has not yet been set, interested nominees will make statements to the Council before a final vote on the position. (***Update***: Since the meeting, Jelousy removed his name from the list. The two candidates for community co-chair are Jimmie and Chata. A vote will be taken at the Nov. 13 Council meeting.)

Member Absences

- John Newmeyer and Maria Rinaldi called to inform the co-chairs of their absence from today's meeting. John West also notified the co-chairs that he would be arriving late due to Jury Duty. Henry Ocampo previously notified the Council (at the 10/9 meeting), that he would be absent through December 1, 1997. Tracey also indicated that Lyn could not attend today's meeting, therefore Rick would be filling in for her.

2. REVIEW AND APPROVAL OF 9/25 MINUTES

Chata informed the Council that there was a quorum present to approve the minutes of September 25. He asked if there were any comments, revisions or questions for these minutes. There were none. A motion

and a second were made to approve the September 25 minutes. With a quorum present, the September 25 meeting minutes were approved.

3. MEMBERSHIP COMMITTEE - Proxy Voting Discussion and Public Comment Revisions
Chata introduced the Membership Committee and asked that those Committee members present begin their presentation. Barbara explained that that after the Committee's September 25 Council meeting presentation, the Committee members discussed and incorporated the suggestions and feedback provided by Council members into the text of the Proxy voting document. A revised Proxy Voting document was distributed and Ellen asked that Rick highlight what the specific revisions to the text were.
Rick summarized the following additions and changes:

- There are no limits to the number of proxy votes that can be cast for any given vote, however proxy votes can never out-number the votes in the room.
- Proxy votes will not be counted in the quorum.
- Members are limited to voting through proxy at only one (1) Council meeting per quarter.
- Co-chairs will not be allowed to cast a proxy vote on behalf of other members.
- The proxy vote protocol will apply to HPPC meetings only and it is not applicable to the Committees. (*Committees are responsible for establishing their* own *policies and procedures.*)
- Members who notify the Co-chairs of their proxy by telephone, must also submit written notification before the next Council meeting.
- Proxy votes will be recorded as such to differentiate them from regular votes.
- Proxy votes may be used during concept and/or binding votes.
- Only HPPC voting members can either use a proxy vote or hold a proxy for another member.

Ellen opened the floor for Council discussion about the above changes to the proxy vote protocol and the proposed changes to the by-laws as a result of Council approval of said protocol.

Council Discussion Pertaining Proxy Voting
Jimmie asked for clarification pertaining to the proxy vote limit of one per quarter. Specifically he inquired as to who would be responsible for recording the number of proxy votes any given Council member exercised during each quarter. Chata suggested that perhaps the task could be assigned to the process evaluation team, since they have past experience tracking similar data such as the Council members' absences. Jimmie indicated his approval of Chata's proposal.

Michael stated that he liked the changes that were made to the original document and supported the proposed proxy vote protocol to be included in the by-laws. Sonja indicated her support of the document as well. However, she noted that the Committee might consider adding some language to the document that would indicate that a designated proxy voter may choose to abstain from a vote due to new information that may arise during Council discussions previous to any vote. Ellen agreed and suggested the text stipulate that designated proxy voters have the ability to: *vote in favor, oppose or abstain from any given motion.*

A motion and a second were made to accept the proxy vote protocol inclusive of the changes mentioned above. Ellen facilitated the vote.

In Favor :	14
Opposed:	0
Abstained:	1

Motion passed. Ellen explained that Council members interested in utilizing a proxy should first notify the Co-chairs (Ellen, Chata, or Tracey), in writing the name of their chosen proxy. Once a proxy is on file with the Co-chairs, members need only contact the Co-chairs when initiating their proxy for a given meeting and/or votes. Brian added that this proxy voting protocol will now be included in the language of the by-laws with changes from this meeting.

4. MEMBERSHIP COMMITTEE - Public Comment Discussion and By-Laws Changes

Steven summarized that the Membership Committee proposes that the existing public comment policy be revised to include the following: First, during the business meeting of each month (usually the first meeting of the month), any public statements and or comments that are not related to the agenda of that meeting may be expressed at the beginning of the meeting. No more than ten minutes will be allotted to this initial public comment, with a three minute limit per speaker. Second, a public comment period will be included to each agenda item (perhaps 10 minutes for each hour of an agenda item), in order to allow community input during Council discussions. During the second meeting of each month, the public would be invited to participate fully in the discussions on all non-business agenda items. (i.e., educational topics, presentation on research data, updates on HIV prevention in specific communities, etc.). Steven indicated that this proposal would demonstrate the Council's commitment to substantive community involvement.

Michael stated that public input could easily generate additional Council discussions. In order to allow adequate response to public comments he recommended that the time allotted to each agenda item for public comment be moved from the end to the middle of each item. Steven agreed and added that the Committee had intended to allow public comment to be heard and discussed by the Council members prior to any vote or decision that would be made.

Chata stated that although he is an advocate for community involvement in this planning process, he is concerned that the proposed item by item public comment might hinder the Council's ability to complete its tasks. He noted that this proposed process would require a proficient facilitation in order to assure that both the community is heard and the Council is able to complete its obligations. Ellen agreed that the facilitation would be the key to the success of this process. She explained that the Committee had intended that the allotted time after each agenda item not be restricted to public comments alone, but rather that it would be open to anyone present, public and/or Council members. She explained that after the joint discussion, inclusive of public and Council comments, the meeting would revert back to a closed discussion for Council members only.

Jimmie suggested that in the event that many individuals were interested in participating in the proposed public comment (after each item), the discussion during the time allotted may be structured in such a way that would differentiate the Pro's and Con's of each issue. Ellen indicated that this would only be required when discussing a two sided issue, rather than when the Council was soliciting community suggestions and feedback. In reference to lack of available time to hear all individuals interested in commenting, Steven stated that although it is not favorable, the Council does and has postponed issues when deemed necessary.

Chata asked for clarification pertaining to possible conflict of interest when discussing prevention topics that affect providers during the business meetings. Steven indicated that the Council's obligation is to discuss 'prevention' and not 'providers.' He added that if an individual's direction seemed to be moving towards a specific provider(s), the facilitators for the discussion would have to intervene. Chata stressed that due to past experiences, he strongly recommends that policy be developed to deal with such situations.

Tracey noted that many Council members are themselves providers therefore conflict of interest would also apply to them in such circumstances. Currently the Council is in the process of developing a conflict of

interest policy, in terms of voting. In terms of input and discussions the current policy draft stipulates that conflict of interest must be acknowledged. However, she pointed out that the public would not be voting, therefore the issue of conflict of interest would be diminished.

Sacul recommended that specific language be included in the public comment section that would indicate flexibility in regards to the time allotted for each speaker, being that not all individuals can articulate their comments as quickly as others. Steven agreed and proposed that a clause be added that stated additional time allotted by decision of the Co-chairs. Tracey pointed out that the Co-chairs would be able to assess the need for more time, by reviewing the public comment sheets. In addition, any Council member can request that more time be allotted to a specific issues.

Sonja indicated her concern that if this protocol is accepted, it may be difficult to revise at a later date. She suggested that the protocol be launched as a pilot, for a period of a few months to determine its effectiveness.

Ellen summarized the suggestions given by the Council:

- Move the open comment during the business part of the meetings -- instead of at the end of discussion.
- Extend the time allotted for each issue, at the discretion of the Co-chairs.
- Facilitator to organize the discussion into pro's and con's for any given issue on the floor.
- Launch as a pilot from the beginning of November 1997 to the end of January 1998.

A motion and a second were made to accept the public comment protocol, with the above mentioned suggestions. Ellen facilitated the vote.

In Favor :	15
Opposed:	0
Abstained:	0

Motion passed unanimously.

5. BREAK

6. PRESENTATION AND DISCUSSION ON THE MAYOR'S HIV/AIDS SUMMIT

Ellen introduced herself as one of the Co-chairs of the Mayor's HIV/AIDS Summit Prevention sub-committee. She introduced sub-committee members present and noted that Josh Bamberger, Michael Discepola, Valerie Kegebein, Dawn Passar, and herself would be presenting today. The sub-committee members then distributed several handouts to the Council.

Ellen explained that the creation of the Mayor's HIV/AIDS Summit had been driven by the Mayor's desire to address two primary issues, workplace re-entry and insurance coverage for people with HIV. The Mayor began by assembling a Steering Committee which is chaired by Tom Coates and Marcus Conant. The Steering Committee developed a planning structure for the Summit, that included seven sub-committees: Access to New Treatments, Compliance to New Treatments, Workplace Re-entry, Testing and Reporting, New Models of Prevention, Insurance Coverage and Looming Future Issues. The Summit is not intended as an all-encompassing conference on AIDS, but rather a group meeting to discuss the latest changes in the epidemic -- new ways of thinking, development of new policies to address changes, etc. She noted that just as several of the sub-committees have conducted public forums regarding their assignments,

the prevention sub-committee wanted to bring their efforts to the attention of the HPPC for input, inclusion and feedback.

Ellen summarized that the goals of the Summit are to conduct focused discussions in order to develop some specific policy recommendations that will be presented to the Mayor for public dissemination. It is the desired intent that the recommendations emerging from the Summit will not only be implemented, but that they fall into the comprehensive vision of public health in San Francisco. She added that having the Mayor as a spokesperson for the recommendations -- that were compiled from actual community input -- will be a powerful method for focusing attention on these very pertinent issues.

Ellen reported that the Summit is scheduled to occur on January 27, 1998. However, the Mayor will be making an initial announcement on December 2, 1997, pertaining to some of the recommendations. She added that the guest list is currently being compiled and indicated that all members of the HPPC will be invited. The Summit will be very inclusive allowing for 1,500 invited guests and an additional 1,500 slots for interested members of the public.

She explained that the sub-committee has had an interesting task in that they have been working in the context in which the City of San Francisco already has a prevention planning council that makes policy and recommendations. Part of what the sub-committee attempted to do is determine how not to overlap the Council's efforts by addressing the areas that are beyond the scope of this particular Council. Ellen stated that the sub-committee began by exploring the possibilities of what the Mayor, given his authority, could say about HIV/AIDS prevention that would have a positive impact on the public. The sub-committee came up with four general areas: *Structure, Tension between behavioral and medical prevention strategies, Behavioral complexity (psychological issues), and the Link between HIV/AIDS and mental health, substance abuse, etc.*

In response to a request for clarification, Ellen responded that the intent of this presentation was to solicit input and feedback from the Council. She then introduced Valerie to discuss the first area specified by the sub-committee, *Structure*.

Valerie indicated that it was very important to acknowledge that the underlying principles of the Summit closely correspond to those of the HPPC. She stated that the sub-committee is aware that they will not have any control over what the Mayor chooses to implement, however, they agreed to ask that the Mayor acknowledge the following ideas to the communities participating in the Summit.

- That the City of San Francisco has an existing Prevention Planning body -- HPPC -- that has developed priorities and strategies.
- That there is new consensus data, as well as other new data.
- The Mayor and the community should understand who is being funded to provide various activities and prevention efforts.
- That there is a need for a mandatory gathering of providers to discuss current trends in the epidemic.
- That the Mayor advocate for expanding the existing interventions.

Valerie stated that these were just five of the eight ideas the sub-committee is asking the Mayor to address. She asked that Council members review the remainder of the bulleted ideas, and then comment on them at the end of the presentation. She added that ultimately the sub-committee wanted the Summit to be clear that the prevention field is not just the AO and its prevention providers, but that it is a large and diverse

group including epidemiology, behavioral and social science, public health, non-AO funded agencies, and CBO's.

Josh Bamburger introduced himself and indicated that he had been brought into the sub-committee because of his work with the Post Exposure Prevention Project. Josh reported that since the project opened its doors on October 15, they have had a number of people come in seeking counseling and testing, as well as treatment for post exposure prevention. The results have been extremely powerful and successful. He added that the success is not necessarily because of the availability of the medication, but rather because of the ability to access those individuals with complex psychosocial needs. The project has been able to identify the clients' needs and then counsel the client accordingly to prevent future exposure to HIV. He pointed out the second area specified by the sub-committee, *Tension between behavioral and medial prevention strategies*.

Josh explained that in the past, prevention strategies have focused primarily on behaviors. But, in lieu of the medical advances being made, the prevention strategies must be modified to include the other types of interventions, such as medical and psychosocial interventions. He indicated that the sub-committee is asking that the Mayor acknowledge the following:

- Not being exposed to HIV is still the best prevention.
- Research must be conducted before service changes are implemented.
- We need to ensure responsible media around PEP.
- The best medical intervention would be a vaccine.

Michael D. discussed the third area specified by the sub-committee, *Behavioral complexity (psychosocial issues)*. He explained that he wanted to first address the third bulleted paragraph, which he felt was most important for this area. He stated that current prevention efforts have failed to keep up with the behavioral complexities of risk taking behaviors. He noted that the majority of programs target behavioral risk, but fail to target the other co-factors of risk such as self-esteem, poverty, depression, lack of negotiating skills, health issues, etc. Michael stated that addressing these issues, as well as the issue of behaviors, will most likely increase the chances of an individual getting out of the behavioral risk pool. With this in mind the sub-committee decided that they would ask the Mayor to advocate for an incorporation and increase of client driven interventions and a reduction in the didactic presentations of "AIDS 101."

Michael then referred to the remaining bulleted paragraphs. He pointed out that the sub-committee is asking that the Mayor acknowledge and support the following:

- Inform the community that we care. Although there are still people getting infected, the message needs to be heard that there is hope and there is a future.
- Prevention messages need to target both HIV negative and HIV positive individuals.
- Prevention needs to be more integrated and cross-disciplinary with substance abuse and mental health programs.
- Encourage programs to understand and truly incorporate harm and risk reduction strategies.

Dawn discussed the fourth area specified by the sub-committee, *Link between HIV/AIDS and mental health, substance abuse, etc.* She explained that the there are far too many populations that fall through the cracks because they do not seek out traditional health care services. Some of these populations include the homeless, individuals with mental health issues, commercial sex workers, immigrants, etc. Because addressing immediate needs leads to receptivity for HIV prevention messages, as well as helping people

reduce harm, the sub-committee agreed that the overarching recommendation would be to strengthen the social service system. Dawn explained that given that this is very broad, the sub-committee also developed more specific recommendations to include with the overarching recommendation. Dawn then listed the specific recommendations:

- Support needle exchange; stop harassing clients.
- Law enforcement must enact recommendations from the Prostitution Task Force and end harassment of commercial sex workers.
- Support condom distribution in school.
- Support treatment on demand and the work of the Treatment on Demand Task Force.
- Support Lesbian, Gay, Bisexual and Transgender community centers and linkages for gays, lesbians and transgenders; building community is an HIV prevention strategy.
- Sex clubs provide an option for education. Keep them open as a means to reach patrons.
- Stop harassment of illegal/legal immigrants; people need to feel safe to change risk behaviors.
- Expand services for gay youth -- both in and out of schools.
- Provide age appropriate sex education in elementary through high school. Ensure that the curriculum includes information about choices, self-efficacy, skill building, gender power imbalances, homosexuality, and reproduction. HIV education should be taught alongside STD education and teen pregnancy prevention programs.

Ellen explained that these are the recommendation that the sub-committee has developed so far. She stated that the final product will be a five to ten page document on the basis of these recommendations and any feedback the Council might provide. She then asked the Council for any questions, feedback, or suggestions.

COUNCIL RESPONSE TO MAYOR'S SUMMIT PRESENTATION

Barbara asked for clarification pertaining to the Testing and Reporting sub-committee. She expressed her concern that information was not included in this document about the controversial issue of "name reporting." It was clarified that the Testing and Reporting sub-committee was separate from the Prevention sub-committee that was presenting today. Ellen explained that the only reason that the issue had not been addressed in the Prevention sub-committee was that they had not discussed it in the Prevention Committee. She added that it seemed appropriate to enforce themes across the sub-committees of the Summit and requested that Barbara specify what she would want the Mayor to say about Testing and Reporting. Barbara stated that Counseling and Testing is an integral part of prevention in that many people will visit an HIV testing clinic and never step foot in a prevention building. Focus should be given to the concern that name reporting might hinder people from coming in for Counseling and Testing. She added that it was difficult to articulate the depth of the concern with the limited time. Valerie suggested that the Prevention sub-committee address the issue by stating that Counseling and Testing is prevention and is recognized as such, and then reiterate Barbara's comments. She also suggested that the Testing and Reporting sub-committee might want to get in contact with Counseling and Testing providers, to get their perspective. Ellen noted that she would bring the issue up at the next Steering Committee meeting. Sonja added that Steve Heilig, Co-chair of the Testing and Reporting sub-committee, was considering participating in the public comment section of the next HPPC meeting.

Chata thanked the Steering Committee, the sub-committees and the Mayor for their efforts to provide the Summit. He explained that his preference would be that the Mayor recognize that there is a planning process in place in San Francisco that includes a comprehensive plan. The Mayor should reiterate that this planning process serves as a model to the nation. He pointed out that much of the information discussed by

the prevention sub-committee, such as the linkages to mental health, are evident in the HPPC Plan. Chata expressed his concern that the sub-committee discussed 'appropriate' messages but yet never mentioned culture which affects individual behaviors. These messages need to be relevant for all populations, not just the highest risk. With all of the culture and diversity found in San Francisco, there is a need to focus on how to reach even the most disenfranchised individuals in our communities. Chata then referred to Barbara's comments pertaining to Testing and Reporting and stated that the Council needs to initiate a discussion pertaining to this and other similar issues -- such as needle exchange. The Council must develop policies that address these issues and their effect on prevention strategies. Chata also suggested that the sub-committee broaden the issue of responsible media, to include all issues and not just PEP.

Askia referred to the information presented by Michael D. pertaining to the behavioral complexities of risk taking behaviors. He stated that that this information is not news to him. He noted that this information is a given, providers should be asking their clients about what's happening their lives. Askia stated that he did not see a need for a Mayor's group to convene and re-invent the wheel.

Michael agreed that these questions are being asked and addressed by workers, but it is not being asked by the media campaigns. He agreed that most of the recommendations are not new ideas. However, the intent is to develop new ways to present and bring focus to them. Michael noted that in terms of the issue of cross training, the intent is to equip prevention providers with the tools -- mental health, substance abuse, etc. -- to effectively help and empower their clients.

Tracey indicated that she would like the Mayor to say that HIV prevention works and needs to continue to combat this epidemic. Steven seconded what Tracey stated. He indicated that the sub-committee should consider being more inclusive. He pointed out that there was only one mention of STD's and language about 'negotiating skills' was nowhere in the document. Given that there are many things that we know work, we need to included them. He also suggested adding information pertaining to other issues such as relative health, TB, etc.

Jimmie stated that overall the document seemed structurally sound. However, he expressed his concern that the document was not inclusive of all populations. He pointed out that only a few specific populations were mentioned -- gay youth, commercial sex workers, etc. He recommended that the sub-committee consider the need to be more inclusive when making the recommendations, specifically addressing older gay men who have borne this weight of the epidemic in San Francisco.

Elizabeth stated that she would like the Mayor to tell the police to back off. The Mayor needs to urge the police to back off people who are trying to make a living whether it's commercial sex workers or outreach and service providers who are trying to stop this epidemic. She suggested that a strong message be sent out specifying the need for police to become educated about the community and its needs. Sacul agreed and added that the sub-committee should emphasize that police training is very important.

John W. indicated his concern that the recommendations would be perceived as 'window dressing.' He explained that there are too many worthy topics being addressed in the document to allow for any of them to be adequately addressed. He suggested that the sub-committee consider prioritizing the recommendations to address those topics that are considered being of greater importance. He asked for clarification as to the amount of time that the sub-committee was being allowed for their presentation. Ellen responded that each sub-committee would have thirty minutes to present and thirty minutes for questions and answers from participants. John W. stated that although he was not able to make any recommendations to the sub-committee as to which of the topics had greater importance, he stressed that the sub-committee choose their arguments carefully. Liz seconded John's suggestion to focus on specific

topics. She referred to the section that indicates support for gay, lesbian and transgenders. She suggested that the sub-committee include bisexuals among the language of the report, especially bisexual men who don't identify as gay. She explained that she is not asking that the population be listed synonymously with gay, but rather that it be addressed as an important factor affecting prevention efforts.

Ellen agreed with the suggestions to condense the recommendations and highlight fewer points. She reiterated that the final product will be both the Summit recommendations that the Mayor will enact, which may not necessarily be the recommendations that will be presented publicly at the Summit, but also the production of a five to ten page document of recommendations and background rational that the Mayor will have the opportunity to act on.

Sonja stated that the document seemed to contain many generalizations. She inquired as to what type of follow-up was expected from this event. Ellen indicated that in December there will be an initial discussion to highlight the recommendations. The Summit will occur on January 27, and then the document will be completed after the summit to allow for the incorporation of the input from the Summit. Sometime during March/April there will be a follow-up press conference on the progress of enacting the recommendations. Sonja indicated that although it is good to be focusing the media's attention on these very important issues, she would rather see all the money that is being spent on this Summit going to the actual prevention work. She stated that the participation of the community should be a given and not just a once a year or media event.

Ellen indicated that this process is on-going and that anyone interested in providing additional input can forward the information to her. She explained that the sub-committee is looking to have the first draft of this document by the end of November. On behalf of the sub-committee she thanked everyone for their participation and input.

7. CLOSURE/EVALUATION

Tracey thanked everyone and asked that members complete their evaluation forms before leaving.

Attached to these minutes for absent members:

- Letter from Mobilization Against AIDS International, pertaining to proposal reviewers.
- Proxy Voting handout.
- Public Comment handout.
- Mayor's HIV/AIDS Summit overview.
- New Directions in Prevention -- Mayor's HIV/AIDS Summit sub-committee draft.
- "Process Evaluation Results" and "Participant Dialogue" box from the October 9 meeting.
- AIDS Office - Urgent Notice: "Condom Recall."

Attached to these minutes for all Council members:

- Information pamphlet for the November 19, 1997 conference: "The Changing Face of Drug Treatment: Bridging the Gap Between Abstinence and Harm Reduction."

Minutes Recorded by: Amalia Fernandez-Niewendorp, Polaris R & D, Inc.
Minutes Approved by: Ellen Goldstein, Co-chair and Tracey Packer, AO Co-Chair.

HIV PREVENTION PLANNING COUNCIL MEETING

NOVEMBER 13, 1997
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

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Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer

Please read: **Agenda/Linkages Committee Report**

Please bring: **Entire meeting package**

1. Food/Welcome/Introductions/Announcements *(new members will be introduced)*	Ellen Goldstein	3:00 - 3:30 PM
2. Public Comment	Ellen Goldstein	3:30 - 3:40 PM
3. Review and Approval of 10/9 and 10/23 Minutes	Ellen Goldstein	3:40 - 3:45 PM
4. Linkages Committee-Cultural Competency Principles and Tool (Concept Vote) *(includes 10 minutes public comment)*	Sacul L'Adnbre	3:45 - 4:45 PM
5. Evaluation		4:45 - 4:50 PM
6. Break		4:50 - 5:00 PM
7. Roles & Responsibilities Document (Acceptance Vote)	Ellen Goldstein	5:00 - 5:20 PM
8. Community Co-Chair Candidate Statements and Election (Vote)	Ellen Goldstein	5:20 - 5:35 PM
9. Statement from Director of HIV Prevention Questions & Answers	Barry Brinkley	5:35 - 5:55 PM
10. Closure/Evaluation	Tracey Packer	5:55 - 6:00 PM

Upcoming Meetings:

HPPC Meeting - Thursday, November **20** 1997, **3-5** PM, First Unitarian Church 1187 Franklin Street (@ Geary)
HPPC Meeting - Thursday, December **11**, 1997, **3-6** PM, First Unitarian Church 1187 Franklin Street (@ Geary)
HPPC Meeting - Thursday, December **18**, 1997, **3-5** PM, First Unitarian Church 1187 Franklin Street (@ Geary)

SF DPH

HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for November 13, 1997

* Please note in your calendar any of the following meeting times that apply to you: *

HPPC:	Thurs., Nov. 20, 3-5 p.m. at the First Unitarian Church
	Thurs., Dec. 11, 3-6 p.m. at the First Unitarian Church
	Thurs., Dec. 18, 3-5 p.m. at the First Unitarian Church
Linkages Committee:	Mon., Nov. 24, 12-2 p.m. at the AIDS Office
	Mon., Dec. 8, 12-2 p.m. at the AIDS Office
Assessment Committee:	Wed., Dec. 10, 3-5 p.m. at the AIDS Office
Evaluation Committee:	Mon., Dec. 15, 3-5 p.m. at the AIDS Office
New Member Orientation:	Thurs., Dec. 4, 3-5 p.m. at the AIDS Office
	Thurs., Dec. 18, 1-3 p.m. at the AIDS Office
	Thurs., Jan. 15, 1998, 3-5 p.m. at the AIDS Office
	Thurs., Jan. 29, 1998, 3-5 p.m. at the AIDS Office

Members Present:
Ronnie (Chata) Ashley
Elizabeth Davis
Michael Discepola
José Ramon Fernandez-Peña
Ellen Goldstein
Jelousy Jiggetts
Sacul L'Adnbre
Jennifer Lorvick
Sonja Mackenzie
Byron Mason
Askia Muhammad
Jimmie Naritomi
John Newmeyer
Shawn O'Hearn
Tracey Packer
J. Colin Partridge
Dawn Passar
Jeff Poltl
María Rinaldi
Steven Sams
Nashanta Stanley
Steven Tierney
A. Toni Young

Members Absent:
Barbara Adler
Marcos Bañales
Bill Barnes
Michael Bogan
Manny Dacalanio
Brenda Escobar
Kevin Gogin
Liz Highleyman
Dave Hubbard
Dredge Byung'chu Kang
Valerie Kegebein
Helen Miramontes
Henry Ocampo
John Blake West
Renee Williams

AIDS Office Staff:
Barry Brinkley
Brian Dobrow
Mike Pendo

Guests:
Shelly Chen, SFSU
Julie Ginsburg, SFSU
Ramona Holloway, SFBCA
Mazdak Mazarei, Lyric
Sara N. McLanahan, CDC NAC
Larry Meredith
Joshua Volle
Kiki Whitlock, API Wellness Center

Harder + Co./Polaris, Inc.:
Amalia Fernandez-Niewendorp, Polaris, Inc.
Rick Green, Harder + Co.
Lyn Paleo, Harder + Co.

HPPC Process Evaluation Team:
Ruel Caneda

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1. FOOD, WELCOME, INTRODUCTIONS, and ANNOUNCEMENTS

Ellen convened the meeting shortly after 3:00 p.m. On behalf of the Council she welcomed its newest members (13 total.) She asked all members and guests to introduce themselves. She then asked whether there were any announcements.

Announcements

Member Absences

- Ellen reported that the following members called to inform the co-chairs of their absence from today's meeting: Barbara Adler, Marcos Bañales, Michael Bogan, Liz Highleyman, Valerie Kegebein, Helen Miramontes, and John Blake West. For the benefit of new members she explained that members who are going to be absent, arriving late, or departing early from Council meetings, should notify the Co-Chairs as early as possible.

Elizabeth Davis

- The Membership Committee is currently recruiting veteran Council members to serve as mentors for the newest members. Those interested may contact her at 415-554-8472. Ellen added that the 'New Members Committee' orientation will be a series of four, two hour meetings. A list of those meeting dates and topics was distributed and an invitation was extended to any HPPC members interested in attending.

Dawn Passar

- Dawn informed the Council that the API Wellness Center would be conducting its first open house on November 14, between 5:00 and 8:00 p.m., at 730 Polk Street, Fourth Floor. She extended an invitation to all HPPC members interested in attending.

Ruel Caneda

- Ruel indicated that the handout, "Process Evaluation Methods and Documents" was distributed with the 10/23 HPPC meeting evaluation results. Although the handout is intended for newer members, Ruel suggested that it may be useful to all.

Tracey Packer

- Tracey reminded the Council that, due to the Thanksgiving holiday, the second meeting of the month will be on November 20 from 3 - 5 p.m.

- She also reported that the State Office of AIDS Representative, Sandy Simms, will no longer be attending Council meetings. Her replacement will be Dave Hubbard who plans to attend his first meeting on December 11.

- She explained that the State of California Department of Health Services Office of AIDS, has a working group similar to the HPPC called the Community Planning Working Group (CPWG). The CPWG is currently accepting nominations for participation in that group, and Tracey encouraged Council members to seriously consider participating in that group. Currently there are only two members from San Francisco serving on the group that are not DPH representatives, and the CPWG is interested in having more community representation and involvement.

- Tracey also provided an update on the "Supplemental Funding." She indicated that six months ago the AO had been notified by CDC that additional funding in the amount of $719,000 was earmarked for San Francisco prevention activities. The Council initiated a Supplemental Funding Task Force (SFTF) consisting of HPPC members and AO staff. The SFTF identified unmet needs in San Francisco by populations, strategies and interventions as well as other activities. The AIDS Office awarded $300,000 to 18 agencies for this year and into 1998. An additional amount of funding will be allocated through an RFP process early in 1998. All of the contracts (18) went through the Health Commission Process and are scheduled to begin December 1, 1997.

  The AO is also in the early stages of planning a series of community focus groups to help to assess the community's reactions to and concerns about general prevention issues, needs, and Post Exposure Prophylaxis (PEP). PEP is a 28 - day course of medication treatment that can be given to individuals who believe they might have been exposed to HIV within the last 72 hours. PEP has been found to be a potentially effective method for occupational exposure to HIV, and currently San Francisco has begun a pilot study to assess its feasibility and behavioral impact with other

types of exposures to HIV. The pilot test includes numerous components such as counseling, provider training, and an informational campaign. She explained that the HPPC has discussed and indicated its concern about the consequences of misinformation about PEP. Tracey explained that the primary intent of the PEP informational campaigns is to combat misconceptions about PEP. She indicated that the AO will continue to provide periodic updates to the HPPC on the results of the AO efforts.

Toni noted that there were at least two pilot studies being conducted in San Francisco. Tracey agreed and added that the information from all studies, as well as the focus group findings, would be utilized in the development of the PEP informational campaigns.

Chata requested an update on filling the gaps in services to the Native American Community that had been identified during the supplemental funding process. Primarily, he was interested in how the AO was planning to address those gaps. Tracey explained that the AO had not received any applications to serve that particular community. She indicated that the AO Prevention Unit has discussed possible methods, such as an RFP or sole source funding, that could facilitate the distribution of the funding recommendations indicated by the SFTF. The AO is committed to filling the gaps identified by the SFTF. However, they have yet to come to any final conclusions. She reiterated that the AO Prevention Unit is committed to keeping the HPPC informed of *any* developments or results of their efforts through periodic updates.

Ellen Goldstein

- She informed the Council that the University of California San Francisco (UCSF) AIDS Research Institute is sponsoring an 'Inaugural Event and World AIDS Day Commemoration' on December 1, 1997. The event is scheduled from 2:00 to 5:00 p.m. at the Cole Hall Auditorium located at UCSF, 513 Parnassus Avenue. She explained that UCSF AIDS Research Institute is an umbrella organization that links the approximately 44 separate components of AIDS Services, Research and Treatment at UCSF, into one structure. She indicated that invitations for the event will be mailed out to all Council members.

- Ellen indicated that the theme of World AIDS Day this year is 'Give Children Hope in a World with AIDS.' She referred to a resource booklet from the CDC and the American Association for World Health. The booklet includes fact sheets on various aspects of HIV/AIDS: planning involvement and participation in World AIDS Day activities, media outreach guide, and various other resources. She explained that the HPPC Co-Chairs had discussed the idea of HPPC participation in World AIDS Day activities. One idea was the development of a summary list of events/activities that are occurring in San Francisco in order to help publicize those activities and events. She then asked if Council members had specific events/activities in which the HPPC could participate, support or endorse for World AIDS Day.

  Steven Sams indicted that at 9:45 a.m. a service will be held at the National AIDS Memorial Grove, in Golden Gate Park. He also reported that the AIDS Emergency Fund is running an all day 'Every Penny Counts' collection drive at Union Square. There will be live radio broadcasting and television coverage while more than 100 Bay Area middle schools, high schools, and businesses bring in their collections.

  Chata referred the group to a selection from the resource booklet pertaining to "The Rights of the Child in the Context of HIV/AIDS." (*Copy attached for all members.*) He suggested that the

Council consider endorsing this selection as well as composing a letter of acknowledgment and support of the authors, the World Health Organization Global Programme on AIDS.

- Ellen sorrowfully announced the passing of Bethsaida Ruiz's partner, Carol Young. Brian indicated that information about services and donations were available for all members at the back table. Ellen asked for a moment of respect for Bethsaida and her partner.

2. PUBLIC COMMENT

Ellen explained that the HPPC had recently agreed to initiate a new protocol for public comment. The new process stipulates that public comments unrelated to specific agenda items will continue to be addressed shortly after the meeting announcements. This public comment period will last for ten minutes with a three minute per person limit. Individuals interested in participating must first fill out the public comment request form that is located at the back table. Completed forms are then submitted to any of the three Co-Chairs.

The protocol for public comments pertaining to specific agenda items is slightly different. Once agenda items have been presented and discussed by the full Council, the discussion will be extended to include participation from all interested individuals -- including guests and/or non-Council members. The full meeting discussion -- inclusive of members and non-members -- will last for a period of ten minutes, after which time Council members-only participation will resume.

Ellen indicated that no Public Comment request had been submitted to the Co-Chairs for this meeting.

3. REVIEW AND APPROVAL OF 10/9 AND 10/23 MINUTES

Ellen informed the Council that there was a quorum present to approve the minutes of October 9 and October 23. However, she pointed out that the 10/23 minutes had just been distributed therefore the Council would postpone their review and approval until the 11/20 meeting.

Ellen then asked if there were any comments, revisions or questions for the 10/9 minutes. There were none. A motion and a second were made to approve the October 9 minutes. With a quorum present, the October 9 meeting minutes were approved.

4. LINKAGES COMMITTEE -- CULTURAL COMPETENCY TOOL (Concept Vote)

Ellen introduced Sacul L'Adnbre, the Chair of the Linkages Committee. Sacul welcomed the new HPPC members and extended a warm greeting to all of the veteran HPPC members. She began by introducing the rest of the Linkages Committee members: Chata A., Sonja M., Marcos B., Dawn P., Hector C., Delia G. (AO), and Rick G. (Harder + Co.)

Sacul reported that, since their last presentation to the Council, the Committee had disseminated a Provider Survey to solicit community input on the Cultural Competency Assessment Tool. The survey went out to 200 HIV/AIDS CARE and prevention service providers. The Committee experienced an excellent response rate of 23% (46 out of 200.) The survey was an opportunity for community members to provide input into the development of the assessment tool, as well as evaluating the Committee's work. Sacul indicated that all of the input received was valuable, but the written comments of respondents were especially thoughtful and constructive. All of the input received, from the Council as well as the community, provided the Linkages Committee with a clear direction for improving the tool.. Once the Committee received and reviewed the input, they began the process of incorporation. After some revisions, deletions and additions, the Committee agreed upon the Cultural Competency Assessment Tool Draft Questions (Fourth Draft) that

was being presented today for a concept vote. Sacul introduced her co-member Sonja Mackenzie to provide a brief overview of specific input received and the resulting changes to the tool.

Sonja reported that the Committee had thoroughly considered the Council feedback (minutes from the 10/09 HPPC meeting), before addressing the input from the provider survey. She summarized the feedback received for each of the eleven questions and the changes which they influenced as follows:

Q1: List Target Group and Program.
The feedback received by the Committee indicated that this question might prove to be problematic when listing 'sub-cultures within the target groups.' The Committee agreed to include clarifying language that would guide an agency when describing the subcultures. The following sentence was added: *"When defining subcultures you may want to consider race, ethnicity, age, sexual orientation, geography, class, SES, risk behavior, etc."* Another modification was to re-order the columns -- to match the order of the question.

Q2: Subculture of staff, board, etc.
The only significant change made by the Committee to this question has been to modify the request for volunteer information into an 'optional' response. Sonja did note that additional feedback to this question had also indicated some apprehension from respondents pertaining to the intent of the question. (Sonja stated that Chata would re-visit this question again during his presentation.)

Q3: Language.
Community feedback to this question indicated a need for clarification as to the level of fluency a provider had in language(s) spoken by their clientele. The Committee agreed to add the word '*fluently*' to this question as well as a column to indicate the languages spoken by the clients. Sonja further explained that direct client contact is generally limited to the front line staff and management/administration staff. With this in mind the Committee decided to remove the request for '*language spoken by the board and volunteers*.'

Q4: Cultural Competency Trainings.
This question raised the most controversy. Feedback indicated a need to simplify the question format. The Committee agreed to change the format to an open-ended question and also to request information from the agencies pertaining to the training provider -- inclusive of their qualifications. Sonja added that the Committee also agreed to include clarifying language pertaining to the different types of trainings possible -- culturally specific, as well as general issues that increase an agency's cultural competency. (Sonja noted that Chata would also re-visit this question during his presentation.)

Q5: Points of entry.
The format of this question was modified to include an area for the specific language(s) used by the agency's for their points of entry. (i.e., newspapers, billboards, flyers, referrals, etc.)

Q6: Degree of clients determining services.
The intent of this question had confused many respondents. Sonja explained that the Committee had developed the question in order to determine whether an agency utilized a client centered approach. However, after much deliberation the Committee agreed to delete the question from the tool.

Q7: Methods used to collect information of target group(s).
Feedback pertaining to this question was conflicting. Although it ranked high as an indicator of cultural competency, respondents also felt that was too burdensome. In order to rectify this problem the Committee agreed to modify the question by requesting that agencies list all methods used but only describe the most successful method of those listed. (Sonja indicated that Chata would also re-visit this question during his presentation.)

Q8: Norms that are barriers.
This question was very well received by the community. Many respondents felt it would reflect the agency's cultural competency. However, respondents also noted that communities are more than a series of problems that need to be solved. The Committee agreed to include language about the resources and strengths of the population being served and the means by which the population overcomes the barriers they face. The Committee also included an additional example barrier: '*language.*'

Q9: Participation in events.
The feedback received indicated that this was not a good indicator of cultural competency. The Committee agreed to delete this question from the tool.

Q10: Ways to become involved.
This question was well received by the community. The question has not been modified.

Q11: Evaluation of cultural competency.
Respondents were supportive of this question, but indicated that it was rather burdensome. The Committee agreed to simplify the question by deleting several irrelevant components of the question, such as who designed, who conducted, who saw, etc.

Sonja thanked the Council and introduced Chata for the next item of the Committee presentation. Chata explained that the Committee incorporated as much of the feedback as possible. However, he noted that the Committee found it difficult to approach and/or incorporate the feedback received on Questions 2, 4, and 7.

Q2, Subculture of staff, board, etc. Chata noted that, although some input had been incorporated into this question (previously stated by Sonja) the Committee was unable to incorporate the following feedback. He then read a quotation from a respondent pertaining to this question: "*Staff experience these surveys to violate their privacy. They feel trivialized – like they are tokens – when we request they self identify in order to comply with the County's need to know.*" Chata stated that the Committee was interested in getting feedback from the Council on how best to address this situation.

Toni agreed that, perhaps, the question was a bit intrusive. She explained that in a case of a monocultural agency, disclosure of more 'personal' aspects of staff lives would be difficult. She added that, although the Committee is attempting to expand culture past ethnicity the Committee might also consider that the act of requesting and/or scrutinizing more specific 'personal' information is often culturally unacceptable.

Elizabeth said that her preference would be to continue to request cultural and sub-cultural information about all persons involved in the agency/program, particularly the board members. She explained that the board members in most cases are the final decision makers, therefore they should be representative of, as well as advocates for, the target population.

Chata explained that the biggest concern pertained to disclosing HIV status. He agreed with Elizabeth's comment and expressed his preference that board directors reflect the community they serve.

Maria expressed concern with the kind of feedback that was received for this question. She said that as a prevention service provider, some amount of disclosure is necessary to effectively reach your clients. Disclosure can only improve the quality of the services provided. If an agency does not want to demonstrate its connection to the population it serves -- by indicating shared cultural or sub-cultural compatibility with the population -- how can we assume they are capable to serve that population? She questioned the motives of those who would not want to demonstrate their agency's ability to reflect their client population. She reiterated the previous comments that this question needs to be asked, especially of board members.

José Ramon stated that he had no problem with the tool as it was presented. He asked the Committee to clarify the method that would be used to evaluate the information collected by the tool. Chata responded that the Committee had not yet gotten to the implementation phase of the tool. However, he indicated that the Committee had agreed that **all** of the tool questions would be utilized in the evaluation of agencies' cultural competency.

Tracey indicated that the implementation of the tool had not yet been finalized. However, the Committee had agreed that the tool will be included as an addendum to future RFP's, as well as the program monitoring process. She stated that, having participated in the last several Committee meetings, she was privy to the Committee's struggle with the subjectivity of the assessment tool. Although there is Committee consensus that the tool assesses cultural competency, it relies on subjective judgment. She informed the Council that this Committee has met its goal to develop a sound concept of assessing agencies cultural competency. However, the implementation phase of the assessment will be a task for next years Linkages Committee.

Steven Sams thanked the Committee for all of their work and supported the deletion of the 'check boxes.' He said that it has been his experience that the issue of disclosure, particularly pertaining to HIV, is and will continue to be a controversial issue. He pointed out that the existing laws pertaining to this issue are vague and the Committee might want to consider making that type of information request optional.

Jimmie noted that he was concerned that the tool did not clearly indicate whether it was to be completed by a specific program or the entire agency. If the expectation was for the entire agency, then it could be a problem. Some agencies are multi-service organizations. This tool would require a disproportionate amount of time to complete. The same would apply for agencies that were interested in collaborative efforts. Ellen responded that this cultural competency tool process should be no different than the standard RFP practice. Agency(s), whether it's one or fifteen, proposing a program must respond to the stipulations of the RFP. Additionally, since the implementation mechanism for the tool is yet to be developed, it is premature to begin discussing such issues.

Ellen suggested that the Committee open the floor for public comment. Sacul agreed, and called on Joshua Volle. Joshua offered his wholehearted support for the Committee's work. He suggested that the HPPC consider conducting site visits to some of the community agencies to address issues that came up. This would allow for the solicitation of direct input and provide an opportunity for the HPPC to clarify and dismiss any misinformation about the tool and its intent.

Dawn noted that a recent client interaction had given her additional insight on the crucial need for 'language' as a cultural competency indicator. A Thai speaking client was recently turned away from a clinic because staff could not communicate with her. Instead of referring her to another clinic, that might have been able to communicate and understand her need for birth control pills, the agency allowed her to fall through the cracks. Unfortunately, the consequence of this event was an un-planned pregnancy.

> *Q4, Cultural Competency Training.* Chata stated that feedback on this question indicates that most trainings vary considerably in terms of content and quality. The Committee wonders whether the responses to this question will provide enough information to the reviewers in order to make accurate assessments of the quality of the trainings. Ellen suggested that a definition be included that would clarify the types of trainings possible. She also recommended that the Committee pilot test this question in order to get a better sense of the sort of information that agencies would be submitting.

José Ramon indicated that this question is two questions, in one. It not only solicits what an agency has done, but it also allows the agency the opportunity to demonstrate its commitment to increase the staff's ability. Tracey suggested that the Committee might also consider asking a brief sub-question about how the staff felt about the training: Did it meet the staff needs/expectations, did it improve their ability to work with the target population?

> *Q7, Methods used to collect information of target group(s).* Chata stated that some respondents felt the tool was too long and complex. Considering the amount of energy and resources that are required to complete the RFP process, the Committee would like to know how the Council feels about the length and contents of the tool. Is it too much to ask an agency to complete? In Chata's opinion, the tool is not too much to ask. If an agency is requesting funds to serve a specific population, then they should be committed to demonstrating their ability to do so.

Michael Discepola suggested that the Committee review past RFPs in order to identify and utilize the fundamental RFP language in the cultural competency assessment tool. Tracey indicated that since RFPs are modified each time they are initiated, she would recommend that the Committee develop the most comprehensive tool possible.

Chata stated that, after reviewing all of the Council and community feedback the Committee came to the conclusion that there were three additional questions that they felt needed to be asked in the assessment tool. Chata asked for Council feedback on whether they should include these three questions. The three possible open-ended questions are:

- Please explain why your agency is culturally competent to serve the clients it targets.
- How well do you feel this tool measures your cultural competency?
- What does your agency do to improve or maintain its level of cultural competency?

Jeff indicated that these questions appear to address some of the issues raised by Question 2. He suggested replacing that question with these open-ended questions. Sonja responded that while the new open-ended questions did address some of the issues discussed pertaining to 'Q2.', the Committee felt that these new open-ended questions would be less specific.

Jimmie indicated his preference that the Committee take into consideration the duplication of effort that might result from the RFP and the cultural competency assessment tool. Colin expressed support for the

open-ended questions, that allow for a more interactive approach. He also encouraged the Committee to consider a client-based assessment of the agency(s) cultural competency.

Joshua Volle indicated his approval of the qualitative questions, but expressed his preference that they not replace any of the quantitative questions. He stated that both are required to effectively evaluate cultural competency. He supported the idea of assessing an agency's cultural competency from the client perspective, although admitting that it would be a laborious task. He also offered that another good indicator of cultural competency was how well an agency is linked to other agencies that serve the same population. Lastly, he commended the Committee for the wonderful job that they are doing.

Kiki Whitlock thanked the Committee for soliciting the input from Community Based Organizations(CBO) in the development of this tool. She indicated that that type of community involvement, allowing CBOs ground level access, is imperative. Byron asked for clarification as to how the sample size and respondents had been chosen. Rick responded that the AO had provided a list of 200 HIV/AIDS CARE and Prevention Service Providers that had contracts with them.

Michael Discepola indicated his support of the three new questions, and reiterated the comments of other members and non-members, by stating that the questions allowed agencies to respond in their own words. He also agreed with Kiki that how well an agency is linked to other agencies that serve the same population, is a good indication of cultural competency.

Sacul thanked everyone for their participation. Before moving on to the concept vote on the tool, Sacul asked that any additional comments be forwarded to Rick Green, of Harder + Co., at fax number 415-522-5445. She explained that the Committee's next steps will be to incorporate the feedback in order to present a final draft to the HPPC -- for a final vote -- on December 11, 1997. On behalf of the Committee, Sacul thanked Rick for all of his hard work. Sacul then requested that Ellen resume facilitation of the meeting in order to explain and complete the Concept vote.

Ellen briefly explained that the HPPC had initiated the notion of Concept voting several years ago to serve as an indicator of the Council's position on the Committees work. The concept votes are not binding and only serve as 'temperature readings' of the Council, whether it is in favor or opposed to the Committee's direction. She indicated that the Council was being asked for a Concept vote on the direction of the Linkages Committee's cultural competency assessment tool.

In favor:	15
Opposed:	0
Abstain:	0

Ellen noted the Concept vote unanimously supports the direction of the Linkages Committee's work. She asked that everyone please take a few minutes to complete the presentation evaluation before taking a quick break.

5. BREAK

6. ROLES & RESPONSIBILITIES DOCUMENT (Acceptance Vote)

Ellen reconvened the meeting and distributed "Roles and Responsibilities Document Quick Overview." She summarized that the HPPC went through its first year of implementation without a clear delineation of the DPH/AO and HPPC purviews. Hence, the Steering Committee accepted the task of defining the roles and responsibilities of each. After initial discussion the Steering Committee evolved into the Roles and

Responsibilities Task Force. The task force deliberated for many months, in order to develop the final document that was presented to the Council on 8/14. Jimmie provided the Council a summary of the development of the document -- background and context information. On 9/11, the task force completed its presentation of the document by reviewing the contents of the document and informing the Council that Dr. Katz had approved the document. HPPC members provided two recommendations for revising the document: 1) Section J - Mutual Accountability: Include language pertaining to 'respectful engagement' under both the DPH/AO and the HPPC responsibilities. 2) Section L -- Grievance Procedures: Clarify *which* mediation service would be used and the rationale behind the selection.

Ellen indicated that was evident that there was a need for Council members to further review the document. The Council agreed to complete a more thorough review of the document, and to forward their feedback to Lyn Paleo by 9/17. At the 10/9 HPPC meeting, the task force reported that it had not received any Council feedback on the document, and would extend the deadline through the end of October. Ellen noted that, as of 11/13/97, the task force had not received any additional Council feedback. Given the amount of time that was allotted, she suggested that it was time to conclude this order of business, with a vote for or against the use of the document.

Ellen summarized that the document's twelve sections can be divided into two types of descriptions: 1) HPPC Process' and 2) Role Clarifications. She explained that the HPPC Process sections are the descriptions of the processes in which this Council is engaged. The task force set standards for those descriptions with the provision that they would be subject to modification as needed (probably through the work of the Membership Committee). Regarding Role Clarifications, Ellen indicated that these descriptions were not created by the task force. The task force simply clarified the roles that are stipulated by the CDC guidelines. The Council may comment and make recommendations on any of these Role Clarification descriptions. However, they are not open for modification.

Ellen then summarized the content of the roles and responsibilities document as follows:

HPPC Roles & Responsibilities

- Select new members
- Retain/remove members
- Develop & approve by-laws
- Identify priority populations, strategies, and interventions
- Review/approve Plan
- Write letter of concurrence or non concurrence with DPH application
- Review RFP (members w/out conflict of interest)

AO Roles & Responsibilities

- Appoint new members
- Contract with planning support consultants; monitor contracts
- With consultants, prepare Plan
- Implement HPPC recommendations
- Write CDC application for SF funding
- Allocate resources; awards funds
- Write RFP, conducts bidder's conference
- Select proposal reviewers

Shared Roles & Responsibilities

- Develop Planning Support plan
- Develop meeting agendas, timing, facilitation
- Plan each year's activities
- Supply data, information experience
- Conduct assessments
- Develop implementation plans for committee work (implemented by AO)
- Conduct oversight research projects

She added that processes outlined in the document are as follows:

- Principles of mutual accountability, respect, responsibility.
- Conflict resolution: a series of steps with timely responses.
- Chain of Authority for grievance procedures.

Ellen asked if there were any questions, additions, or revisions. There were none. There was a motion and a second to accept the Roles and Responsibilities Document as a working document for the HPPC.

In favor:	11
Opposed:	0
Abstain:	2

With a quorum, the motion to accept the Roles and responsibilities document passed. Ellen indicated that copies of the document were available at the back table.

8. COMMUNITY CO-CHAIR CANDIDATE STATEMENTS AND ELECTION (Vote)
Ellen summarized that the position of Community Co-Chair -- filled by Chata the last two years – was beginning a new term from January 1998 to December 1999. HPPC members had nominated two candidates for this position at the last meeting: Jimmie and Chata. She explained that the Co-Chairs together should represent a balance of gender, ethnicity and experience. She then introduced the two candidates for their personal statements.

Jimmie expressed his gratitude to the Council for considering him for the position of Community Co-Chair. He stated that he is a consistent and compassionate individual who would utilize the many lessons learned from his past experiences, including the Chair of the Resource Allocation Committee, to serve as a facilitator of the Council's efforts. He added that his commitment to the process is evident by his past participation in the Council and its Committees. If elected he would readily take off his Co-Chairs 'cap' should the need arise. He would speak his mind, and strive for full Council participation as well as community involvement. He would do his best to serve the Council and would do battle for its members whenever necessary. He concluded by stating that regardless of the results of the vote, he believes that both candidates would be good Co-Chairs.

Chata expressed his appreciation at having been able to serve as the Community Co-Chair for the last two years. He explained that he had not realized the full extent of the responsibilities that came with this position, until the end of his first year. He admitted that it has been a very challenging last two years, and commend all members new and old, that have shared so much of themselves in this process. Prevention and community planning does work, particularly when there is structure such as the HPPC that has evolved from advocacy to planning in the last two years. He commended the AO staff who have proven to be extremely hard working and committed individuals who fully support the Community planning process. He thanked the Council for the nomination and the opportunity to serve the community for two more years.

Ballots were distributed to Council members eligible to vote, all veteran Council members. Brian instructed eligible members to fill out the ballots, and then submit them either to Lyn or himself. He explained that the ballots would be tallied and the results would be announced to the Council at the end of the meeting.

At this time Membership Committee members briefly summarized the recently adopted Proxy Vote protocol for new members. Elizabeth stated, that when a Council member is unable to physically participate in a vote he/she may assign a proxy voter to cast his/her vote. Jelousy added that Proxy Voters must be chosen out of the current HPPC member pool, written notification must be submitted to the Co-Chairs prior to any proxy vote. Members may use their Proxy no more than once per quarter. Copies of this protocol are available from the Membership Committee.

9. STATEMENT FROM DIRECTOR OF HIV PREVENTION (Question & Answers)
Ellen introduced Barry Brinkley, of the DPH/AO. Barry expressed his gratitude for the opportunity to work with the HPPC in their efforts to prevent HIV in San Francisco. He noted that he has been fortunate to be involved in the public health initiatives that are going on at the macro level in the DPH. He introduced the Director of Health Promotion and Prevention for the City and County of San Francisco, Mr. Larry Meredith. Barry explained that the re-organization of the DPH that has been taking place over the last year has resulted in the three newly identified major branches under the DPH rubric: 1) Community Health Services: HIV direct services. 2) Community Health and Safety: EMS, etc. And, 3) Health Promotion and Prevention Services. The latter will focus not only on HIV prevention, but will also include an initiative to promote the health and well being of all the citizens of San Francisco. He indicated that at this time the largest proportion of funding for that particular branch is focused in the HIV prevention division. (Total funding is in the neighborhood of $16,000,000 -- with $13,000,000 in HIV Prevention funding.)

He explained that the HPPC's role in this overall process is to continue the excellent community planning which it has demonstrated to date. The HPPC is not only part of an excellent planning process on the local level, but at the statewide level as well. Barry identified four specific areas that are instrumental in the facilitation of the DPH/AO and HPPC efforts to prevent the spread of HIV, and the continued success of this local planning process: Commitment, Cooperation, Communication, and Contribution.

He acknowledged the **commitment** to this planning process made by everyone on this Council. Although the Council has done an excellent job to date, the process requires continual quality improvement. This is something that must be done each year as the HPPC and DPH/AO address such issues as cultural competency, service accountability, etc. The **cooperation** between the HPPC, DPH, CBO's and the communities who receive services, is just as important. Ultimately, the shared efforts of all these entities, will result in meeting the goal to end the spread of HIV in our communities. **Communication**, or rather lack of communication, has hampered the efforts of many a planning process. However, through determination and the use of a circular model of communication, that barrier can be overcome. He prefers the latter model of communication, as opposed to a linear 'top down' model. The circular model, allows for a multitude of perspectives, that will assist in reaching the goal that is stipulated in the Plan: "To end the spread of the HIV disease by the year 2000." Lastly, he pointed out that, by accepting their appointments to this Council, each member has pledged to contribute their time and energy to this necessary process. Members are expected to attend and participate in the two monthly Council meetings, and any additional Committee meetings. He acknowledged the sacrifices made by Council members, and noted that it is a noble task that they are engaging in. He summarized that these types of contributions have resulted in the funding that has been awarded to this City to complete the work that will prevent the spread of HIV.

Over the next year the HPPC will have the opportunity to work with other sections of the Health Promotion and Prevention Services branch in the joint planning within the DPH to promote the health and well being of everyone in the City. The DPH will keep the HPPC informed regarding that process and will also solicit feedback from the Council on how it can be improved. The HPPC collaboration is not limited to just the AO staff it includes the entire DPH, the consultants from Harder + Co., Polaris, and the Process Evaluation team. He then asked Council members for comments, questions, or suggestions. He announced an open door policy, and expressed his optimism at the collaboration and work to come.

In response to a question, Barry replied that the most pressing issues facing the effort against the HIV epidemic were as follows: (He indicated that this list was not prioritized.)

- Needle Exchange: How to assure treatment on demand.
- Increase in STD rates: A potential for an increase in HIV infections.
- Youth 14-25: A need for effective prevention efforts.
- Communication between **all** external systems to promote the health and well being of all San Franciscans. To look outside of the $13,000,000 and to figure out how to leverage all of the other activities that are going on in our communities to battle the epidemic. Including engaging the Faith Community. People have minds, bodies and spirits. All three components must be addressed.

He stated that, in addition to these four major issues, there is also the issue of the structure of the DPH/AO. More specifically, the issue of accountability in the program management. He expressed his belief in the Japanese concept that means "continuos quality improvement." With the perspective of step-by-step improvement the DPH/AO will be able to improve all of its processes. Whether it's the planning process, orienting new members of this body, or new DPH/AO staff, or building capacity within our communities.

Chata asked what the partnership -- between the DPH/AO and the HPPC -- could do to reinforce trust back into the community regarding the community planning process. He also asked what assurance there was for the continued support of the community planning process and of the recommendations of this Council from the DPH/AO. Barry responded that the track record of the DPH/AO reflects a process of growth and learning. Since the community planning process is fairly new, the DPH/AO has had to educate itself about this new process. His commitment and participation in this Council and the Statewide planning process, speaks of his commitment to that empowering process. The checks and balances of his commitment will be demonstrated in his participation, and the participation of his team at the Council meetings. The DPH/AO representatives are here as public servants, and they will build trust in the community and the Council through their actions.

José Ramon identified a tension growing in the last two years between organizations that serve people with HIV/AIDS and organizations that provide prevention services. More specifically, he referred to the lack of available funding and how it must be divided into competing programs. In this age of protease inhibitors this competition is even more apparent. He asked Barry what role the DPH/AO could play to assure the continued collaboration of these two sides. Barry responded that there were several things that could be done to address this issue, but communication would be the key. Having worked on both CARE and prevention, he understands how important it is to have both components, care and treatment, secondary prevention and primary HIV prevention. However, he stated his belief that it would be better to make the initial investment in primary prevention, to avoid having to pay the more costly consequences. This problem has many levels, including political, social, and economic. Even though there has been a 70% increase in HIV funding since 1993, it is still not enough. The solution lies in the communication and collaboration of the two sides and the utilization of the external systems that are resources for our efforts to prevent the spread of HIV: Inter-faith community, media, schools, etc.

Dawn suggested that the DPH/AO Health Promotion and Prevention Services branch consider the immigrants and undocumented individuals who live in San Francisco when focusing on their HIV prevention/promotion of health and well being. She agreed that communication is the key to success in any language. She reiterated her request that the DPH/AO consider the non-English speaking people of San Francisco in their efforts.

Shawn recommended that the DPH/AO look into the implementation of the peer advocacy model in all languages. He noted that, when funding stops, gaps are created and the epidemic continues. He suggested a collaboration with community colleges as part of the utilization of the external system mentioned by Barry. He also requested that the DPH/AO consider funding models that genuinely work.

Ellen thanked Barry for his presentation. She extended an invitation for him to conduct updates and information presentations in the future. Barry accepted and thanked the Council for their time and comments.

7. COMMUNITY CO-CHAIR ELECTION RESULTS, CLOSURE, AND EVALUATION

Tracey thanked both of the candidates for participating in the election and then announced that Chata had been elected as the Community Co-Chair for January 1998 through December 1999. She thanked everyone and asked that members complete their evaluation forms before leaving.

Attached to these minutes for absent members:

- HPPC New Members Committee Meeting Dates and Topics.
- "Process Evaluation Results" and "Participant Dialogue" box from the October 23 meeting.
- "Process Evaluation Methods and Documents" handout.
- Application for the HIV Prevention Community Planning Working Group.
- Service and donation information for Carol Young.
- Cultural Competency Assessment Tool (Fourth Draft.)
- Roles and Responsibilities Quick Review and Roles and Responsibilities Document.

Attached to these minutes for all Council members:

- "The Rights of the Child in the Context of HIV/AIDS," from the World AIDS Day Resource Booklet, published by the American Association for World Health.
- 12/11/97 HPPC Meeting Agenda.
- Letters from the Local Infected and Affected Native Two Spirited Community.

Minutes Recorded by: Amalia Fernandez-Niewendorp, Polaris R & D, Inc.
Minutes Approved by: Ellen Goldstein, Co-Chair, and Tracey Packer, AO Representative

HIV PREVENTION PLANNING COUNCIL MEETING

NOVEMBER 20, 1997
3:00 PM to 5:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer

1. Food/Welcome/Introductions/Announcements	Tracey Packer	3:00 - 3:15 PM
2. Review and Approval of 10/23 Minutes	Tracey Packer	3:15 - 3:20 PM
3. Strategic Evaluation Committee - Identification of Gaps in Intervention Level Evaluation Research (Concept Vote)	Colin Partridge & Michael Discepola	3:20 - 4:20 PM
4. Cost Effectiveness of Prevention Interventions	John Newmeyer	4:20 - 4:40 PM
5. Process Evaluation Report-Supplemental Funds	Kathleen Roe	4:40 - 4:55 PM
6. Closure/Evaluation	Tracey Packer	4:55 - 5:00 PM

Upcoming Meetings

For meetings at the AIDS Office, please ***always*** check in with the receptionist on the 5th floor.

HPPC Meeting - Thursday, **December 11, 1997, 3-6** PM, First Unitarian Church 1187 Franklin Street (@ Geary)

HPPC Meeting - Thursday, **December 18, 1997, 3-5** PM, First Unitarian Church 1187 Franklin Street (@ Geary)

HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for November 20, 1997

* Please note in your calendar any of the following meeting times that apply to you: *

HPPC:	Thurs., Dec. 11, 3-6 p.m. at the First Unitarian Church
	Thurs., Dec. 18, 3-5 p.m. at the First Unitarian Church
Linkages Committee:	Mon., Dec. 8, 12-2 p.m. at the AIDS Office
Assessment Committee:	Wed., Dec. 10, 3-5 p.m. at the AIDS Office
Evaluation Committee:	Mon., Dec. 22, 3-5 p.m. at the AIDS Office
	Mon., Jan. 5, 4-6 p.m. at the AIDS Office
New Member Orientation:	Thurs., Dec. 4, 3-5 p.m. at the AIDS Office
	Thurs., Dec. 18, 1-3 p.m. at the First Unitarian Church
	Thurs., Jan. 15, 1998, 3-5 p.m. at the AIDS Office
	Thurs., Jan. 29, 1998, 3-5 p.m. at the AIDS Office

Members Present:
Ronnie (Chata) Ashley
Marcos Bañales
Bill Barnes
Michael Bogan
Manny Dacalanio
Elizabeth Davis
Michael Discepola
Brenda Escobar
Ellen Goldstein
Liz Highleyman
Dredge Byung'chu Kang
Valerie Kegebein
Sacul L'Adnbre
Jennifer Lorvick
Sonja Mackenzie
Askia Muhammad
Jimmie Naritomi
John Newmeyer
Shawn O'Hearn
Tracey Packer
J. Colin Partridge
Dawn Passar
Jeff Poltl
Steven Sams
Nashanta Stanley
Steven Tierney
John Blake West

Members Absent:
Barbara Adler
José Ramon Fernandez-Peña
Kevin Gogin
Dave Hubbard
Jelousy Jiggetts
Byron Mason
Helen Miramontes
Henry Ocampo
María Rinaldi
Renee Williams
A. Toni Young

AIDS Office Staff:
Barry Brinkley
Brian Dobrow
Mike Pendo

Guests:
Shelly Chen, SFSU
Julie Ginsburg, SFSU
Cynthia Laird, Bay Area Reporter
Larry Meredith
Stacy Vogan, STD/HIV PTC
Kiki Whitlock, API Wellness Center
Hank Wilson, ACT UP Golden Gate

Harder + Co./Polaris, Inc.:
Amalia Fernandez-Niewendorp, Polaris, Inc.
Rick Green, Harder + Co.
Lyn Paleo, Harder + Co.

HPPC Process Evaluation Team:
Pali Basi
Ruel Caneda
Kathleen Roe
Kevin Roe

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1. FOOD, WELCOME, INTRODUCTIONS, and ANNOUNCEMENTS

Tracey convened the meeting shortly after 3:00 p.m. She welcomed everyone, and asked that all members and guests introduce themselves. She made several announcements, and then asked for Council member announcements.

Announcements

Member Absences

- The following individuals had informed the Co-Chairs of their absence from today's meeting: Barbara Adler, Byron Mason, Henry Ocampo, Maria Rinaldi, Toni Young, Brian Dobrow, Rick Green and Lyn Paleo. Valerie Kegebein would be arriving late.

- Copies of a letter written by Chata discussing his recent election as the HPPC Community Co-Chair were made available at the back table.

- The most recent 1998 HPPC Membership list was made available at the back table.

Steven Sams

- Steven Sams invited members to the World AIDS Day event, 'Every Penny Counts' collection drive. The event is being sponsored by the AIDS Emergency Fund and will take place from 7 a.m. to 4 p.m. at Union Square, with live radio broadcasting and television coverage.

Elizabeth Davis

- Elizabeth reported that the recent 'Mentorship' recruitment by the Membership Committee had resulted in several pairings. However, there is still a need for more mentors. Anyone interested may contact her at 415-554-8472 or Barbara Adler at 415-476-3612.

Chata Ashley

- Chata reiterated the Co-Chairs request for Council participation and/or endorsements for the upcoming and future World AIDS Day events. He indicated that at the last meeting the Council had discussed endorsing both the University of California San Francisco (UCSF) AIDS Research Institute "Inaugural Event & World AIDS Day Commemoration, and the CDC and American Association for World Health resource booklet, "The Rights of the Child in the Context of HIV/AIDS." Ellen asked whether members had received either the invitation to the UCSF AIDS Research Institute event or the resource booklet selection, and was informed that not all members had.

  Ellen observed that it would be difficult for those who had not received the information to endorse the event and the selection. She suggested that Council members submit any suggestions/ideas for Council participation and/or endorsements for next year's World AIDS Day events to the Co-Chairs as early as possible.

Tracey Packer

- Tracey summarized the meeting agenda. She reported that a request for public comment had been submitted to the Co-Chairs by Hank Wilson, of ACT Up Golden Gate. She explained that public comment during this meeting -- the second meeting of the month -- is reserved solely for discussion of agenda items. She indicated that, if there was time available after any of the agenda item discussions, Hank could then present his specific commentary request.

2. REVIEW AND APPROVAL OF 10/23 MINUTES

Tracey asked if there were any comments, revisions or questions for the 10/23 minutes. There were none, and a motion and a second were made to approve the 10/23 minutes. With a quorum present, the 10/23 meeting minutes were approved.

3. STRATEGIC EVALUATION COMMITTEE (Concept Vote)

Today's presentation was the second such presentation received by the Council from the Strategic Evaluation Committee. The Committee was to present the report 'Identification of Gaps in Intervention Level Evaluation Research' and would then ask for a concept vote on the direction of their efforts. The concept vote -- protocol and intent- was explained and Colin Partridge, one of the Evaluation Committee Co-Chairs, was introduced.

Colin thanked Tracey and introduced his co-presenter Michael Discepola. He also introduced the other members of the Strategic Evaluation Committee: Liz Highleyman, John Newmeyer, Henry Ocampo, Kristen Clements, Bethsaida Ruiz, Stacy Vogan, Raquelle Caras (Process Evaluation), Mike Pendo (AO), and Marty Forst (Polaris). He expressed his gratitude to Mike Pendo and Marty Forst for the tremendous amount of work that they have done to support the Committee's efforts. Handouts of the presentation slides were distributed.

Colin explained that the Committee had been assigned a three-level task by the 1997 HIV Prevention Plan. The first level, implementing the behavioral risk assessment at the provider level, was completed. The second level -- to identify gaps in evaluation research on HIV education and prevention interventions -- would be presented today to the Council for a concept vote. The third level working with a study to identify prevention indicators will be addressed by next year's Strategic Evaluation Committee.

Colin reported that the initial review of the literature was conducted through databases, primarily using **Medline**, a database containing 8.4 million abstracts from 3,800 medical journals. The Committee reviewed 104 relevant articles and three prior literature reviews.

The Committee summarized the pertinent data from the articles by the nine interventions identified in the Plan. The Committee also included interventions that were not in the Plan but were deemed significant by the Committee members: Condom distribution and technological interventions (e.g., spermicides, vaccines, PEP, etc.). The Committee categorized gaps in research by interventions, behavioral risk populations (BRP), co-factors, and sub-groups.

Jimmie asked whether the Committee had considered categorizing the gaps by co-variates as well. Colin indicated that the Committee had, and would address that issue later in the presentation. He listed the interventions used in the review as follows, indicating that the Committee would be presenting analyzed data on five of these interventions:

- Venue-based individual outreach (VBIO)
- Venue-based group outreach (VBGO)
- Prevention case management (PCM)
- Multiple session groups (MSG)
- Single session groups (SSG)
- Counseling, testing, referral, and partner notification (CTRPN)
- Individual risk reduction counseling (IRRC)
- Needle exchange
- Media
- Other interventions: condom distribution, PEP, spermicides, vaccines, etc.

Colin reported that as the Committee began to identify gaps within each of these interventions, it became increasingly more difficult to categorize the literature into the existing BRPs. Most of the studies do not use the same groupings for BRPs as are listed in the HPPC Plan. To facilitate the Committee's review process, members agreed to simplify the existing BRP classification system found in the HPPC Plan by reducing the number of BRP categories from twelve to five. Colin then summarized the five categories the Committee had agreed upon. They are: 1) Males who have sex with males and sometimes females (MSM & MSM/F). 2) Injection drug users (all sexual types). 3) Females who have sex with males, and sometimes females (FSM & FSM/F). 4) Males who have sex with females (MSF). 5) Females who have

sex with females (FSF). Then, a matrix format for summarizing and displaying the articles for analysis was developed which included:

- Author(s), title, journal, date, volume, pages
- Target population/site
- Intervention/strategy
- Outcome measures
- Research design/comparison group
- Follow-up period
- Results of study
- Implications
- Limitations of study

The Strategic Evaluation Committee set three general criteria for selecting articles. First, only relevant articles from 1990 to the present would be reviewed. Second, only articles with behavioral outcomes--i.e., specific behavior changes, rather than changes in knowledge, would be considered. Third, articles conducted in the United States would be stressed (some articles from other countries were examined in the literature reviews).

Michael Discepola referred to the handout that presented the article review matrix used by the Committee. He summarized the matrix format, and asked if there were any questions. In response to one member's question, Colin reiterated that the Committee had completed this process for 104 articles. He further indicated that the bulk of the work had been done by Marty Forst and Mike Pendo. Michael then explained that, based on the matrix breakdown, the Committee then devised a formula to determine the gaps in the specific interventions. In other words, the Committee determined which populations and interventions were under studied.

The Committee then began the process of narrowing down the amassed information into more specific categories. At the most basic level, the Committee tried to identify gaps at the intervention level--that is, by intervention type. Then the Committee identified gaps by BRPs and sub-groups. Several criteria (in the form of questions about research article) were developed to help guide the analysis of each article. The primary criteria for identifying the gaps in intervention research were:

- Population at risk
- Date (age) of article
- Site of study (possible comparability to San Francisco)
- Quality of study design (sample size, comparison group, follow-up period, etc.)
- Consistent findings across studies
- Limitations and inconsistencies of the study
- Evidence vs. assumptions

The Committee also developed a scoring system to identify gaps in a more systematic manner. The scores range from zero to 5, with zero representing a total gap in the research and 5 representing no gap at all. This system was used as a general gauge for ranking gaps; it is not a scientifically derived and validated process.

Michael Discepola referred to the handout that depicted the Counseling, testing, referral, and partner notification (CTRPN) flow chart for the study review results. It summarized the total number and types of

studies that had been located, and then reviewed by the Committee. Studies listed as 'National' are those studies that were completed outside of California.

Elizabeth asked for clarification on the number discrepancy found in the CTRPN studies for IDU's. Mike Pendo explained that there had been a total of 22 - IDU CTRPN studies located. However, seven of those were conducted outside of the United States -- Scotland, Brazil, etc. -- therefore they had not been listed in the totals. Michael Discepola added that although the Committee located 87 study abstracts, they had not been able to find and review all of the actual studies reflected in the flow chart.

Colin stated that in contrast to the CTRPN studies, the Condom Distribution flow chart depicted only one study. Although Marty Forst and Mike Pendo had completed their review and synopsis of the intervention articles, the Committee was still in the final review process.

Steven Sams referred to the amount of time it takes for articles to be listed on **Medline**. He asked whether the Committee had considered soliciting input pertaining to more recent studies at the local Community level. Colin responded that the Committee had not only considered it, but they are aware of several longitudinal studies that are under way for which results are not yet available. He indicated that the Committee feels this is a very important issue, especially as the Committee begins to prioritize the gaps. Michael Discepola added that this year the Committee was faced with the task of identifying the gaps. However, once the prioritization of the gaps identified begins, the Committee will have to look closely at what is currently being done.

Hank Wilson of ACT UP Golden Gate indicated that with the advent of Protease Inhibitors, the Council and the Committee should consider the implications of more recent interventions and then prioritize accordingly. He noted that there is a disparity in the information awareness from community to community pertaining to the state of the art medicines and access that is available. Colin noted that any newer intervention studies - or rather gaps in those studies -- would not be identified until the prioritization process began. The concern raised by Hank is important. As a result of such issues, the Committee will probably need to conduct literature reviews again in a few years.

Colin then referred to the handout of the five interventions for which the Committee had completed the review process. The handout listed the intervention types and three categories of gaps identified in evaluation research. The three categories are: Intervention, BRP, and Sub-groups. The Committee identified ***Prevention case management (PCM), Condom distribution,*** and ***Venue-based group outreach (VBGO)*** as interventions with a total gap in research studies.

There are a few studies examining the efficacy of ***Venue-based individual outreach (VBIO).*** However, the gap in BRP research studies includes: **MSM, MSF, FSM,** and **FSF.** The gaps in research for VBIO by sub-groups include: **Intravenous Drug Use (IDU):** Youth < 24 years of age and Speed Users.

Counseling, testing, referral, and partner notification (CTRPN) is the fifth intervention examined. The gaps in research studies by BRP includes: **MSF** and **FSF.** The gaps in research studies by sub-groups include: **IDU:** Youth < 24 years of age, **FSM:** Youth < 24 years of age, SES, Native American, and Asian Pacific Islander, as well as **MSM:** Youth < 24 years of age and SES.

Colin stated that given that the gaps were tentatively identified, the Committee asked that the Council indicate, through comments and ultimately a concept vote, their opinions pertaining to:

Interventions	-- are they all there?
Modification of BRPs:	-- any comments?
Criteria for gaps	-- any additional ideas?
Scoring tool	-- any comments?
Gap identification	-- are we on the right track?
Future goal	-- feasibility of prioritizing identified gaps?

COUNCIL RESPONSE TO PRESENTATION

Jimmie recommended that the Strategic Evaluation Committee consider coordinating their efforts in the matter of modifying the BRPs with the Assessment Committee. Furthermore, he asked for clarification as to whether the identification of these gaps would be used to update the Epi chapter of the HPPC Plan. Colin stated that he was not sure whether this process will be used to update the Epi chapter. The Committee's intent is to utilize the above mentioned process to prioritize the direction of new evaluation research on interventions.

Tracey added that the Committee's results are somewhat separate from the Epi chapter studies, in that these are specific to interventions, and the Epi chapter looks at seroprevalence or behavioral studies of BRPs. The two are separate, and therefore will result in two separate list of priorities. Jimmie agreed, but indicated that he would prefer that the tremendous amount of work that is being done by this Committee be incorporated into other areas. Colin added that what Jimmie is recommending seems to fit into a different level than what the Committee was working on. The Committee would like to use this information to develop an overall statement about research evaluation priorities, as well as producing one page summaries of the types of interventions and how they were implemented for the community as an educational service.

John West stated that although he is supportive of the simplification of the BRPs, he suggests that the Committee look at the larger context of modifying the BRPs.

Mike Pendo clarified that the modifications to the BRPs being discussed are not intended as a direction to re-formulate the Plan, but rather as a way to facilitate the work of the Committee. John West acknowledged the clarification and noted that what was being proposed at the Committee level was a very rational approach that the Council might want to consider. John Newmeyer added that this is also about using resources more effectively. Identifying gaps also serves as a guide for resource allocation. He explained that by identifying the gaps, programs can be informed about the need for the evaluation information pertaining to the specific gaps in interventions. For instance in the case of PCM, where there is not much information available, a program would spend a large part of its resources in evaluation to determine if the intervention actually works. In the case of CTRPN, the information is available regarding the effectiveness of the intervention; therefore the program would spend most of its resources on the service provision.

Steven Sams thanked the Committee for all of their work and indicted the entire process was very easy to grasp. He stated that his only concern was with the modification of the BRPs. Understanding that the modification was a tool for the Committee, he is very resistant to the idea of collapsing the BRPs.

Colin indicated his understanding of the concern and again reiterated that the modifications were intended for the Committee process only. He explained that if the Committee had listed the twelve BRPs, there

would not have been sufficient data in the vast majority of them. Unfortunately, studies are not being conducted by BRP. To come to the conclusions presented today the Committee was forced to hopscotch between BRP and often times the sub-groups, with some assumptions about the behavior risk in between. For instance in the IDU population, the Committee had to bypass the sexual context and dealt with only the needle context.

Dredge asked for clarification as to where the Transgender population was listed under the Committee's process. John Newmeyer indicated that the Transgender population was listed under the same format of the BRP, which is defined by sexual activity. Dredge expressed his concern that the population might be overlooked by that generalization. He also inquired about social event interventions such as softball games, dances, etc. Colin responded that he did not recall any such studies, however, it is his belief that it would fall under the intervention that most closely resembles those types of interventions, such as VBGO. Dredge also asked whether there were any structural interventions that address system wide policy issues. Mike Pendo noted that the Committee has a copy of a Boston study conducted last year addressing that issue.

Ellen added that the CDC is currently developing a Prevention Registry that includes this type of information about completed studies and identifies effective programs.

Jennifer suggested that once the Committee has identified all of the gaps, it should inform the community of the results. She encouraged the Committee to go beyond the formal methods of evaluating and solicit input from the community pertaining to what is working and not working. Ellen agreed and noted the importance of community confirmation in the Committee's work. She suggested that the Committee could distribute a one page handout listing the 104 articles to the local community of San Francisco as well as the research community (i.e., HIV Center in New York, Harvard AIDS Behavioral Research Institute and Jeff Kelly in Madison WI). This would provide the Committee with feedback pertaining to other studies that might have been done. Ellen also asked for clarification as to the type of outcomes the Committee reviewed -- behavior change or mediating change, such as in a harm reduction model. Colin responded that the Committee had looked at both levels.

Jimmie referred to the total gap in evaluation research for PCM indicated by the Committee. He stated that the CDC had begun funding that intervention in San Francisco in 1992 and the final reports for the first cycle of that funding are due December 15, 1997. Being that the reports are program and population specific, it may be beneficial to request copies from the CDC. Colin agreed and stated that it would be a great transition between Level 1, program/provider information and Level 2, research.

Liz indicated that the Committee would provide the Council with a one page handout of the 104 articles that they had reviewed. She asked that members submit any information about other non-published studies the Committee. Mike Pendo indicated that the Committee had discussed and agreed to solicit input from the community once the gaps were identified. He stated that the intent would be to determine if the results were accurate.

Kiki Whitlock suggested that for the sake of consistency, any modifications of the BRPs should maintain the language used in the HPPC Plan. Tracey clarified that the twelve BRP that are listed in the HPPC Plan have <u>not</u> changed. She clarified that because of the language which is used in the research studies, the Committee was forced to collapse the twelve BRPs into the five categories just for the purpose of identifying gaps in evaluation research.

Hank Wilson asked why popper use had not been listed along with speed. Colin apologized and stated that it should read speed and "other." Hank also referred to the comments about social event interventions. It is

his belief that this should be considered separate from VBGO. Liz responded that as with the BRPs, all possible interventions were not listed by the Committee. The Committee again categorized similar interventions in order to facilitate their efforts. She added that as with the BRPs, the interventions are not in the Committee's purview to modify. Only the Council can modify BRPs and create new intervention categories.

Tracey thanked the presenters. She indicated that the Council was being asked for a Concept vote on the direction of the Strategic Evaluation Committee's current process, inclusive of all of the comments provided during their presentation.

In favor:	16
Opposed:	0
Abstain:	1

Tracey noted the Concept vote supports the direction of the Strategic Evaluation Committee's work. The Committee will complete their work and report to the Council in January. She noted that anyone interested in additional information about Strategic Evaluation could review Chapters 9 and 10 of the HPPC Plan or contact any of the Strategic Evaluation Committee members. She also asked Council members to take a few minutes to complete the presentation evaluation.

4. COST EFFECTIVENESS OF PREVENTION INTERVENTIONS

Tracey introduced John Newmeyer for a presentation on the cost effectiveness of the San Francisco prevention efforts. She distributed the MidCity Numbers Monthly Bulletin (Volume 10, Number 6, September 97). She explained that John Newmeyer has been publishing these monthly bulletins for the last ten years.

John Newmeyer began by briefing the Council on his experience in HIV Prevention. He then explained that the Bulletin is a monthly commentary providing quantitative and qualitative aspects of HIV disease. The Bulletin often asks more questions than it answers, as it is meant to be provocative. Not only does it get readers thinking about things, it also provides indication as to what the answers might be or how they might be found. He then referred to the first article in the September bulletin: (1) The Cost Effectiveness of HIV Prevention.

He explained that this article was inspired by the handout distributed by the AO depicting the dollar amounts being allocated for HIV prevention services in San Francisco. He indicated that the story of HIV Prevention in San Francisco has been one of growth and great success. For him nothing in his life has been as gratifying as being part of the victorious efforts to suppress HIV infection in San Francisco. He believes that the current HIV prevention efforts are targeting the last 10% of remaining pockets of infection.

He referred to the Consensus data presented to the Council three months ago that indicated the estimate of new infection for the coming year was 500. This is a marvelous contrast between the estimates of infection from 1982 and 1986. John Newmeyer stated that when he first began working in this area (HIV prevention) the estimates were 8,000 to 10,000, and by 1986 the estimate for IDUs alone was 15,000. He stated that commendations were in order for the successful HIV prevention efforts in San Francisco.

He went on to explain that the contrast to that success is that much more funding is now being spent to reach the remaining pockets of HIV estimated infection (10%). He explained that the reason for this was that all the easy work was done in the first years. The first thing that he was involved in was the campaign to inform San Franciscans from the IDU community that they were at risk for HIV. A brochure was

developed and distributed -- "Shooting Up and Your Health" – which reached approximately the first 1/4 or 1/3 of IDUs in San Francisco. It became apparent that not everyone could practice the risk reduction methods stipulated in the 'word to the wise' brochure, hence in 1986 the "Bleach and Teach" intervention was developed. The next year (1987) brought about the introduction of the Prevention Point needle exchange programs. This last method cut the infection among IDUs considerably, in fact it is estimated that 90% of the feared infection level in 1986 and 1987 did not happen because of these efforts. Instead of 1,500 infections there were 150-200. He indicated that this has remained the seroconversion rate for IDUs in the last ten years. He referred to the Urban Health Study which indicates that the seropositivity among IDUs has remained at around 10%. He stated that the task of the HIV prevention efforts for IDUs in 1998 will be to locate these last 150 people that are estimated to become infected via the needle, and help prevent that. This will be a much tougher task because of dual and triple diagnosis within the population.

John Newmeyer reported that the essence of the cost effectiveness dilemma in San Francisco is that there is less bang for the dollar because the clientele is a lot more difficult to reach. He referred to the fourth paragraph of the article and reiterated its emphasis on the justification of such expenditures. The last paragraph of the first article posed an additional dilemma for San Francisco. The reason that there are such resources available in San Francisco is because of its political clout and prevention expertise. However, what happens when other cities have needs that are equal or possibly greater than San Francisco's? He gave the example of the Bronx, being that it is similar in size to San Francisco and which also has 500 - 1,000 people at risk for HIV seroconversion. He stated that his colleagues from the Bronx have indicated that there is much less effort, financially, being spent there. What will happen when CDC or other providers of funds at the federal level compare the funds being spent in San Francisco vs. the Bronx? A possible scenario would be to attempt to prevent the most HIV seroconversions with the limited resources available. It is his belief that San Francisco will have to face that dilemma in the near future. In such a context it will be difficult to sustain the excellent efforts of San Francisco prevention – which are currently at a maximum level of effectiveness.

He restated that the article poses questions rather than answers them. He indicated that it is possible that the answers will begin to come once the results of the Strategic Evaluation Committee are realized. The research finding will indicate the efficacy of the various interventions, therefore allowing us to confidently state what works and more importantly justify the expenditure of the resources. Lastly, he stated that effective evaluation research is the means by which to justify funding and encourage policy makers to spend the resources.

John asked if there were any questions or comments pertaining to the presentation. Jennifer stated that although the presentation was illuminating it tends to put things in a linear way, that does not reflect the true nature of prevention work. The linear interpretation loses sight of the fact that people's behaviors can be different day to day. Maintaining safe behaviors is an on-going process for which you need on-going efforts, interventions, etc. It's important to say the that these interventions have made huge contributions, but you must also realize that on-going work is required to hold our ground and prevent new infections. John agreed and stated that you could also add to that the new context of poppers, methamphetamines, and other drugs such as GHP, that complicate the prevention efforts. In short, we not only have to sustain the old efforts but we have to deal with new populations and whole new context.

Bill Barnes noted that some San Franciscans have issues that are more pressing than HIV prevention, inclusive of lack of culturally appropriate services. The reality is that many prevention providers are having to address other needs in order to reach a point where the HIV prevention messages can be heard. John agreed and indicated that the upside of that predicament is that as a provider when you address several types of needs you are able to get people housed, get people clean, as well as keeping them HIV negative.

Tracey regretfully indicated that they needed to move on to the next agenda item. She thanked John Newmeyer for his presentation and suggested that this issue be considered as a topic of discussion for the coming year.

5. PROCESS EVALUATION REPORT - Supplemental Funds

Tracey indicated that Kathleen Roe would be reporting on an assessment that was conducted pertaining to the supplemental funding. Tracey summarized that in early 1997 the CDC informed San Francisco that they were eligible to receive $719,000 in supplemental prevention funds. The AO then informed the HPPC and the HPPC decided to develop an ad-hoc committee -- Supplemental Funds Task Force (SFTF) -- to determine how the funds should be spent. She indicated that in the interest of time, she would go into more detail about the process at a later date for the benefit of newer members. She reported that the funds were spent on the following: Provider training for Post Exposure Prophylaxis (PEP), media and counseling around PEP, links between HIV and STD education, assessment about prevention services for women, off-set some lab cost for HIV testing, and finally the SFTF identified eight populations that had unmet needs. The SFTF developed strategies and interventions for those unmet needs and the AO worked with the Council to determine how to get those funds to agencies. The AO developed criteria that were approved by the HPPC and notification went out to AO contractors/agencies that were eligible. The AO was able to fund most applications. The contracts were developed and certified by December 31 of this year which was the goal. She then introduced Kathleen Roe.

Kathleen distributed the Supplemental Funding Phone Survey Update. She indicated that the document lists the preliminary results of eleven surveys. She made a friendly request to Cynthia Laird, of the BAR, that the information in this document not be published, being that there are three to five more surveys that are yet to be conducted. She reiterated that this is only preliminary information, that may change once the other surveys are completed. She added that a complete written report will be made available to the HPPC once the final interviews have been conducted. She noted that the handout was missing the second page, therefore she would present that information via an overhead.

She stated that providers were very eager to participate and get feedback to the Council and the AO. There were a couple of things that she noticed were different from other times that she has queried providers. First, this group of providers really understood the difference between the AO and the HPPC. She indicated that this is a positive statement of the work that the HPPC has done this year. The Council has emerged form the shadows of the DPH/AO as its own entity. She stated that providers know of and about the Council and are interested in providing their input to the Council. Overall there is desire to enter into a better dialogue with the HPPC. Secondly, there seemed to be a great amount of fear among the providers that were interviewed. Kathleen indicated that the surveys were conducted with the executive directors or education directors of the agencies. She reiterated that there was a fair amount of concern about confidentiality and the anonymity. Providers were afraid of retaliation if critical of the process. Because of this, the results of the survey do not indicate who said something , but rather <u>what</u> was said.

She reported that almost all of the providers had a generally accurate understanding of the source of the money. Most knew that it was CDC funds that had to be dispersed quickly, although there was variation in reasons for why CDC had supplemental funds. Providers first learned about the funding in various ways, including HPPC meetings, AO notification, HPPC minutes and grapevine. She noted that the most curious of these were the two providers that first heard of the funding by reading the HPPC minutes. She indicated that these providers do not have representation on the Council, but yet they made the effort of locating and reading the minutes, which indicates a broader interest in the Council. (*She noted that the last listing under 'AO staff member,' had also learned about the funding at an HPPC meeting.)*

Although most providers were excited by the opportunity, others were happy, but a little concerned at the beginning. All of the respondents said that the right people in their agency received the initial letter and that those individuals had made the decision about whether or not to apply. This indicates that the list used by the AO was not only appropriate but very effective. For the most part the individuals who received the letter made the final decision and developed the application. Kathleen stated that this was a much tighter and more effective loop than what was used in the past. Most providers felt that this was a great opportunity and that they were able to meet the deadlines. In contrast to the last RFP process, this time around providers had nothing but praise about the mechanics of applying. They rated both the initial letter and the negotiations with the AO very highly. Almost all appreciated having specific populations, programs and dollar amounts identified and they reflected a general understanding as to why specific programs' activities and populations had been identified for their agencies. In response to a member's question, Kathleen indicated that the survey questions for the most part were open ended and then collapsed into categories.

All providers felt that the proposed program activity was related to their on-going work. However, one provider stated that although it was an extension of the work that they were already doing, it was not a logical one. Kathleen noted that ten of the eleven providers indicated that they had used the HIV Prevention Plan while preparing their applications. Interestingly enough, almost all of the providers said that even with more time, their application process would not have been significantly different. The providers found the application material and support very helpful.

Kathleen stated that although she was not commissioned to ask a question pertaining to the impact of the funds, she had felt it a beneficial source of feedback. All of the providers felt that the augmentation will be beneficial to their agencies. All providers felt that the contract augmentations will have a positive albeit small impact on HIV prevention in San Francisco. She reiterated that the providers were all eager to talk and generous with their time and comments.

She summarized what providers 'really' wanted to talk about during the survey.

- How to learn more about the HPPC.
- How to share innovative programs, community pulse with HPPC.
- How to engage in more dialogue with the AO and the HPPC.
- Is the Plan set in stone?

Kathleen referred to the last bulleted item and indicated that some providers had stated that the Plan is very rigid, requiring that agencies translate what they are doing to fit in the Plan language. It was recommended that what agencies are doing should influence the language and concepts behind the Plan. And that it should be an emerging and continuous process.

Kathleen stated that there was even a deeper level or sub-text than the issues that people wanted to talk about. It is the underlying story that illustrates why these interviews took so much time. The first sub-text was **History**. She noted that almost all of the interviews began with a conversation pertaining to the last RFP process. Although it's a new year, it is a continuous stream of time for most agencies. Kathleen noted that the past is with us and it may take us many years to move beyond it. The manner in which this process was handled, although an indication of the right direction, requires a continued commitment for improvement.

The second sub-text came to her while listening to a radio program. The term used by a Latino man to describe what it felt to be an American fit perfectly with what the providers were saying, "**Hope and Hurt**." Many providers are hopeful and proud of being a part of the prevention community in San Francisco. Some mentioned Barry Brinkley's arrival and philosophy as being positive and hopeful. More specific, was the fact that Barry had already been out to visit some of the agencies. With that hopefulness there was also an underlying skepticism. Kathleen stated that there is a lot of hurt that needs to be addressed and remembered, but yet it seems to be balanced by the hopefulness of being part of this broader prevention community.

The last and most interesting of the sub-texts was the dualism of the **Providers: allies or adversaries?** There seemed to be a lot of animosity between the providers that are AO funded. Providers see the Council as a force that may drive a further wedge between providers or serve as a unifying force for providers. The providers are looking to the Council to bring them together. Many were asking that the Council take their role among the provider community very seriously.

Kathleen thanked the Council. She stated that until the next time the Process Evaluation team is able to present its finding to the Council, she suggested that members ponder what is the appropriate and best role for the Council in relation to the community. She explained that this year's work had been very focused on improving the relationship between the AO and the HPPC. And although it was a tremendous amount of work it seems that the 'internal act' is coming together. The HPPC should begin considering how to consciously extend themselves out into the community. Lastly, how can the HPPC become a unifying force for providers?

Tracey indicated that time had run out. Council members agreed to postpone the Council response to this presentation until the next report from the Process Evaluation Team..

6. CLOSURE/EVALUATION

Tracey thanked everyone for their participation and asked that members complete their evaluation forms before leaving.

Attached to these minutes for absent members:

- Letter to Dr. Katz and the HPPC from Chata.
- Membership List for 1998.
- Strategic Evaluation Committee handouts.
- MidCity Numbers Bulletin, Volume 10, Number 6. September 1997.
- Supplemental Funding Phone Survey Update (Preliminary Results for HPPC discussion only.)
- "Process Evaluation Results" and "Participant Dialogue" box from the November 13 meeting.

Minutes Recorded by: Amalia Fernandez-Niewendorp, Polaris R & D, Inc.
Minutes Approved by: Ellen Goldstein Community Co-Chair and Tracey Packer, DPH Co-Chair.

HIV PREVENTION PLANNING COUNCIL MEETING

DECEMBER 11, 1997
3:00 PM to 6:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer

Please read: **Agenda/Linkages Committee Report**

Please bring: **Agenda, Minutes of 11/13, Linkages Committee materials & attachments to agenda**

1. Food/Welcome/Introductions/Announcements	Ellen Goldstein	3:00 - 3:20 PM
2. Review and Approval of 11/13 Minutes	Ellen Goldstein	3:20 - 3:25 PM
3. Public Comment & Community Concerns	Ellen Goldstein	3:25 - 4:00 PM
4. Linkages Committee-Cultural Competency Principles and Tool (Final Vote) ***(includes 10 minutes public comment)***	Sacul L'Adnbre	4:00 - 4:45 PM
5. Evaluation		4:45 - 4:50 PM
6. Break		4:50 - 5:05 PM
7. Assessment Committee Update	Maria Rinaldi	5:05 - 5:45 PM
8. Closure/Evaluation & Background Survey	Tracey Packer	5:45 - 6:00 PM

Upcoming Meetings:

HPPC Meeting - Thursday, **December 18, 1997, 3-5** PM, First Unitarian Church 1187 Franklin Street (@ Geary)

HPPC Meeting - Thursday, **January 8, 1998, 3-6** PM, First Unitarian Church 1187 Franklin Street (@ Geary)

HPPC Meeting - Thursday, **January 22, 1998, 3-5** PM, First Unitarian Church 1187 Franklin Street (@ Geary)

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HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for December 11, 1997

* Please note in your calendar any of the following meeting times that apply to you: *

HPPC:	Thurs., Dec. 18, 3-5 p.m. at the First Unitarian Church
	Thurs., Jan. 8, 3-6 p.m. at the First Unitarian Church
	Thurs., Jan. 22, 3-5 p.m. at the First Unitarian Church
Evaluation Committee:	Mon., Dec. 22, 3-5 p.m. at the AIDS Office
	Mon., Jan. 5, 4-6 p.m. at the AIDS Office
New Member Orientation:	Thurs., Dec. 18, 1-3 p.m. at the First Unitarian Church
	Thurs., Jan. 15, 1998, 3-5 p.m. at the AIDS Office
	Thurs., Jan. 29, 1998, 3-5 p.m. at the AIDS Office

Members Present:

Barbara Adler
Ronnie (Chata) Ashley
Marcos Bañales
Bill Barnes
Michael Bogan
Elizabeth Davis
Michael Discepola
José Ramon Fernandez-Peña
Ellen Goldstein
Liz Highleyman
Dave Hubbard
Jelousy Jiggetts
Dredge Byung'chu Kang
Valerie Kegebein
Sacul L'Adnbre
Jennifer Lorvick
Sonja Mackenzie
Byron Mason
Helen Miramontes
Askia Muhammad
Jimmie Naritomi
Shawn O'Hearn
Henry Ocampo
Tracey Packer
J. Colin Partridge
Jeff Poltl
María Rinaldi
Nashanta Stanley
Steven Tierney
John Blake West

Members Absent:

Manny Dacalanio
Brenda Escobar
John Newmeyer
Dawn Passar
Steven Sams
Renee Williams
A. Toni Young

AIDS Office Staff:

Barry Brinkley
Delia Garcia
Marshia Herring
Norm Nickens
Mike Pendo

Guests:

Erick Brown, New Village
Thomas L. Eades
Diane Felix, Proyecto Contra Sida Por Vida
Ken Harper, NTFAP
Darrell Joe, Native American AIDS Project
Cynthia Laird, Bay Area Reporter
Mazdak Mazarei, Lyric
Luis Orozco, NTFAP
Sandy Simms, State Office of AIDS
Christopher Smith, Community Member
Mario Solis, NTFAP
Dylan Tierney
Adela Vazquez, Proyecto Contra Sida Por Vida
Stacy Vogan, STD/HIV PTC
Kiki Whitlock, API Wellness Center
Hank Wilson, ACT UP Golden Gate
Fred Yazzie

Harder + Co./Polaris, Inc.:

Amalia Fernandez-Niewendorp, Polaris, Inc.
Rick Green, Harder + Co.
Lyn Paleo, Harder + Co.

Process Evaluation Team:

Kathleen Roe
Kevin Roe

1. FOOD, WELCOME, INTRODUCTIONS, AND ANNOUNCEMENTS

Ellen convened the meeting shortly after 3:00 p.m. She welcomed everyone, and asked that all members and guests introduce themselves. She briefly summarized the meeting agenda and asked if there were any announcements.

Announcements

Member Absences

- The following individuals had informed the Co-Chairs of their absence from today's meeting: Manny Dacalanio, Brenda Escobar, Steven Sams, and Renee Williams. Ellen reminded members of the absentee protocol that stipulates that members must notify the Co-Chairs of their absence prior to any HPPC meetings.

Jeff Poltl

- Jeff Poltl extended an invitation to Council members for the Wedge Program Open House Christmas Party on December 17 at 2 p.m. The Wedge program is a DPH funded program that provides HIV education services to the public schools of San Francisco. It is located at 1540 Market Street, Suite 260.

Maria Rinaldi

- Maria Rinaldi reported that at the recent Steering Committee meeting, Committee Chairs and Council Co-Chairs, discussed the HPPC holiday celebration scheduled for the last meeting of the year -- December 18. She stated that the Steering Committee had discussed the idea of Council members participating in a 'gift exchange.' Ellen asked for a show of hands to determine whether there was Council interest in participating in such an event. There was limited interest from the Council (4 out of the 30 members present), therefore the idea was abandoned.

Barbara Adler

- Barbara Adler updated the Council pertaining to the New Member Committee meetings. She noted that the last meeting was on December 4 and covered the Plan's Epi profile. The next three meetings will be held on: December 18, January 15, and January 29. ***All new members are expected to attend the new member committee meetings.*** She distributed a phone list of the "New Members Mentor Matches" and invited anyone interested to participate in the up-coming meetings.

Kathleen Roe

- Kathleen Roe referred to the Process Evaluation handouts distributed to all members at the beginning of this meeting. She summarized that the five handouts included: the Evaluation Results and Dialogue boxes from the 11/20 HPPC meeting, as well as the Evaluation and Participant Dialogue boxes for today's meeting. In addition, there was an HPPC Members Background Experience handout. Kathleen stated that there were two purposes for this last handout -- to get a sense of the Council's composition, its strengths, possible areas for trainings, and to ascertain the best dates and times for future HPPC and Committee meetings. Kathleen noted that for the first time the Process Evaluation team was requesting that members list their initials on this handout. The reason for this will be to keep track of the Council's composition as veteran members rotate out and new members join.

2. REVIEW AND APPROVAL OF 11/13 MINUTES

Ellen asked if there were any comments, revisions or questions for the 11/13 minutes.

- Jimmie referred to the sixth paragraph on page seven of the 11/13 minutes. He noted that the intent of his request for clarification pertaining to the language in the tool was not about the implementation process but rather the misinterpretation of agency versus program.

- Jimmie then referred to the first paragraph under agenda item eight, "Community Co-Chair Candidates Statements and Election (vote)". He indicated that the term should read January 1998 ***through*** December 1999.

- Shawn first commended the minute taker for her amazing ability to document this process. Secondly he referred to the first paragraph on page fourteen of the 11/13 minutes. He offered a clarification to his recommendation to Barry Brinkley of the AO. Shawn clarified that if the intentions of the DPH -

AO are truly serious about preventing HIV infection among teenagers, then the AO must initiate a dialogue with the Education Department of the City of San Francisco. This is a very crucial and important issue and should be noted as such.

Ellen asked whether there were any other comments. There were none. A motion and a second were made to approve the 11/13 minutes, with the above mentioned changes. With a quorum present and one abstention the 11/13 meeting minutes were approved.

3. EXPANDED PUBLIC COMMENT & COMMUNITY CONCERNS

Ellen explained that, due to the number of people interested in providing public comment at today's meeting, the Co-Chairs had agreed to expand this agenda item to 35 minutes from the standard ten minutes for public comment. She referred to the letters that had been distributed to Council members along with the 11/13 minutes. Ellen stated that the distribution of these letters to the HPPC members was <u>not</u> in any way an endorsement of the letters but rather passing Council mail to Council members. Copies of these two letters as well as a copy of a letter from Norm Nickens of the DPH (a similar statement pertaining to the distribution of the two letters), were available for Council members and guests at the back table.

Ellen then reviewed the 'Rules for Public Comment' and noted that the rules were also listed on a large sign posted on the wall. She stated that because of the agency specific nature of the letters, the Co-Chairs wanted to reiterate and clarify what the Council and the DPH - AO roles are. She indicated that the following information could be found in the Roles and Responsibilities Document that was adopted by the Council last month.

<u>The HPPC's role is</u>: to identify high priority populations and high priority strategies and interventions, while working with the AIDS Office to ensure that the goals and objectives of the Plan are met.

<u>The AIDS Office role is</u>: to select providers, award funds and administer funds.

Ellen asked if there were any questions, there were none. She stated that the first speaker for public comment was Mr. Hank Wilson of ACT UP Golden Gate.

Hank Wilson, ACT UP Golden Gate

Hank wanted to address some specific research issues. He indicated that the results of several studies conducted by San Francisco researchers had not yet been disseminated to the grass roots community. He stated that, although the AO does disseminate some study information, it does not do so frequently enough. He expressed a concern that there is a segment of the San Francisco population that does not visit prevention agencies, but does listen to the radio, reads newspapers, and watches television. He recommended that the Council consider adding a media piece into the prevention plan to assure that these individuals are exposed to this pertinent information.

At the State level, Hank commented about a recent study (authored by Dr. Juan Ruiz) of over 400 young MSM at the Lambda Center. He expressed outrage that the State did not see fit to provide the Lambda Center with the results of that particular study. He noted that the State also did not use the gay newspapers in that city and did not take advantage of multiple pronged strategies to inform the public. He indicated that the particular study had to do with risk factors for unsafe sex: poppers and speed. He stated that gay men need to hear about these two issues over and over again. He urged organizations such as UCSF/CAPS to report findings back into the community in as many ways as possible, including the media. This is particularly important when trying to reach subsets of people

that do not visit the prevention agencies, and it may also be the most cost effective method to reach a larger audience.

Hank reported that the articles on these studies can be found in medical journals. More specifically, he stated that one of the studies pertaining to seroconversion from 1982 to 1992 was conducted by UCSF researchers. The study examined who was seroconverting and what the co-factors of that seroconversion were. Speed was found to be a major co-factor in seroconversion. The second study for which results have not been disseminated pertained to repeat testers and the use of poppers -- nitrate inhalants.

Hank closed with the following questions: *Shouldn't the community be informed of the results of such studies? Shouldn't the community be allowed the opportunity to digest this pertinent information and attempt to self-correct? Should the researchers be responsible for rippling the information back into the community or be allowed to withhold the findings in their "ivory tower?"*

Adela Vasquez, Proyecto Contra Sida Por Vida
Adela indicated that she wanted to address the contrast between the AO needs for units of service and her community's needs. She stated that it has been her experience as a provider that the ability to comply with specified units of service is directly correlated to maintaining a good outreach team. Unfortunately, her agency's outreach team was eliminated. Promises were made pertaining to the needs of her community, and they have yet to be fulfilled. Adela stated that from the perspective of a health educator it is very frustrating that she is expected to provide an incredible amount of work, with very limited support and lack of data. Adela stated that this situation has hindered her ability to provide the services that her community deserves. By being cemented to her contract and the units of service, she is losing her identity within her community. Adela pointed out the need for more attention to communities of color in the battle against HIV/AIDS.

Christopher Smith, Community Member
Christopher stated that he had been the Program Director for New Village, a NTFAP program. He came here today to discuss the need for prevention services for African American gay and bisexual men. He reported that nationwide African Americans represent 12% of the entire population, but 30% of all the AIDS Cases. By the year 2000 it is expected that African Americans will represent 50% of all the AIDS Cases. It is also a fact that in the City of San Francisco, 65% of all AIDS cases in the African American Community involve gay and bisexual men. This does not include the women who seroconvert after they have had sex with gay or bisexual men. There is more than one issue to be addressed. Attention must be paid to the cultural, historical, and social truths of the target populations. The interventions must be designed by and for the target populations. In the City of San Francisco there is only one organization that is providing services primarily for gay and bisexual African American men.

The issue for him is not whether the NTFAP is doing a good job or not, it's that there are people being infected that do not have to be infected. Some would argue that the response of agencies funded by the AO have not taken into account a lot of facts. For him, the bottom line is accountability. It is not just a two way street between the funding organizations and the agencies who provide the services. It must also include the entire community. Just 'throwing out a program' in order to say that funding was provided for a specific population is not sufficient. Programs have to have teeth. They need to connect with someone more than just with platitudes and body parts. They need to connect with the minds, hearts, spirits and souls of the people they are serving. Christopher concluded by saying communities are still dying and there is a need to think differently

about the epidemic. The fact that 50% of the AIDS Cases in the year 2000 are expected in the African American community is not written in stone. This situation can be avoided by thinking differently about the communities and for the communities when designing programs and services.

Diane Felix, Proyecto Contra Sida Por Vida
Diane explained that she began working in the AIDS Prevention field in 1987 with an organization called Community United in Response to AIDS SIDA (CURAS.) It has been her experience that communities of color are always facing crises of one kind or another. Whether its a community based crisis, fiscal mismanagement, the AO, the DPH, or the CDC, it is nothing new. However, there has been some improvement over the last ten years. The community now has a forum in which their voices can be heard, such as this Council. For her it has been a tremendous struggle to maintain focused on the work at hand with so much crisis. Rumors, hearsay, and anonymous letters have always existed in the communities of color. One such instance of crisis occurred in 1991, when a viable organization was shut down because of rumors, hearsay, anonymous letters, and some mismanagement. The people of color took on the task of developing these organizations in crisis without having the expertise. Today many of the organizations have the expertise, and, after ten years of experience, they have learned how best to run the organizations and have successful efforts. However, these organizations require the continued support from the AO. They require the technical assistance, that, although a bit late for some, can still benefit others.

Diane noted that the continued badgering of agencies that are really trying to do a good job can be very frustrating. There is a lot of pain in our community. We must learn to look and use facts when we are on the attack. The community cannot continue to run on hearsay. We must concentrate on the real issues: the actual facts and the needs of our communities.

Erick Brown, New Village
Eric respectfully withdrew his request for public comment stating that Ms. Felix had expressed concerns and beliefs similar to his own.

Luis Orozco, National Task Force on AIDS Prevention (NTFAP)
Luis began by commending the Council members for their commitment to fighting HIV and AIDS. He explained that the prevention messages he was exposed to were very important to him growing up in San Francisco in ensuring his continued HIV negative status. However, he was affected by this disease as friends and loved ones became infected. After working on Capitol Hill in Washington and then in Sacramento, he came to the conclusion that the political climate of these places was not sympathetic to the needs of his communities. He indicated that he left a perfectly good job to return to San Francisco and help combat AIDS in these communities.

Luis stated that as he pursues his work, he is constantly frustrated by having to fight the State Office of AIDS, Pete Wilson, Jesse Helms and other adversaries. On top of that he must be bombarded by anonymous letters and allegations. He is very troubled by the fact that the Co-Chairs would jeopardize the integrity of this Council and the City of San Francisco by distributing these letters. The have also jeopardized the integrity of a perfectly good program that is doing good work within the City of San Francisco. He encouraged the Council to look into the truth by visiting each of the NTFAP programs and looking at the needs of the communities that the programs of the NTFAP are serving. He stated that he is looking forward to working with the Council and its members in the continued efforts to fight AIDS.

Mario Solis, National Task Force on AIDS Prevention (NTFAP)
Mario informed the Council that, as the CEO of the NTFAP, he wanted to specifically address the anonymous letter addressed and distributed to all HPPC members. The letter, that was distributed under a cover letter from the City and County of San Francisco Public Health Department, he feels is filled with baseless and libelous allegations about the NTFAP. He recommended that the Council examine the procedures around distributing any potentially libelous and anonymous correspondence in the future.

Mario stated that the other procedural question that needs to be addressed by the HPPC is how the Council interacts with community based organizations. The NTFAP was not notified that this letter had been received by the HPPC, and that the letter was going to be distributed to the Council members. The NTFAP was not informed of the public testimony pertaining to their program that was to occur at today's meeting. The NTFAP discovered this information through rumors and innuendoes and a few Council members who contacted the NTFAP in a good faith effort, and informed them about the letter and the public testimony. It is his belief that this is not the mandate by which this Council was formed. It is his belief that this Council was set up as a vehicle for people with AIDS and the affected communities. The intent was to provide an opportunity for members of these communities to work hand in hand with organizations that are run to serve those particular communities. The overall goal of this Council is to stop the spread of AIDS. His particular experience with the anonymous letter -- the manner in which it was distributed without notification to the program in question as well as the lack of notification pertaining to the public testimony that was to occur here today -- was very disturbing. As a community member that has been fighting AIDS for the last 12 years, Mario is very disturbed with the manner in which this Council has proceeded concerning this letter.

Concerning the allegations made by this letter, the Council has the ability to review the facts about the NTFAP and the recent audit that they have completed with the AO. Mario explained that the NTFAP audit is public information. It is readily accessible to this Council either by calling the NTFAP or contacting the AO and requesting the information from them. He suggested that the Council consider exercising such steps in the future when the Council receives this type of information.

Darrell Joe, Native American AIDS Project (NAAP)
Darrell has been working as a case manager at the NAAP for two weeks. He was very disturbed when he received the copy of the anonymous letter that has been circulating throughout the NTFAP programs. In regards to the Native American community and the questions the letter posed, he can not answer all of the questions. However he is willing to try. He invited anyone interested or curious about the NAAP to contact him at 415-522-2460.

Darrell received a fax earlier today from the only program in New York City that provides HIV case management services specifically for the Native American community. The program was being de-funded. In comparison to this type of crisis, the allegations of the anonymous letter serve only to belittle the true issues. He reiterated his invitation to all of the Council members and added that he is willing to work with anyone who is interested in working with him.

Fred Yazzie
Fred explained that as a street based outreach worker, he also received a copy of the anonymous letter. First, he indicated that he was unfamiliar with the term 'two-spirited'. Secondly, he explained

that he had collaborated with the NTFAP in the past in an attempt to determine how best to reach the Native American Community. Generally speaking, his experience with the Native American community is that many Native Americans do not visit certain agencies because of the way they are treated at these agencies, and because of what is said about the particular agencies, such as what is said in this letter. Although talk is good, getting out there and doing the work is even better. That's what is important. He invited anyone with questions or comments to contact him, and added that hopefully there will be more outreach workers brought into NAAP, because there is a great need for them.

Thomas Lee Eades
Thomas summarized that he had been involved in the initial prevention planning efforts of San Francisco, had served as a member of the CARE Council and more recently had served on the San Francisco Health Commission. He explained that recently he had resigned from the San Francisco Health Commission because he had been tokenized -- he was appointed because he was gay, infected, and Native American. He had felt as if he had no voice, and, therefore, chose to resign from the Health Commission feeling totally disgusted with the Health Department and the mediocre programs that are habitually put out by the system. He stated that as a person who is living with the disease as well as someone who has spent the last decade advocating for the Native American community, he expects excellence and only the very best. He indicated that the NTFAP has long since proven their ineffectiveness within the Native American community. He added that the community needs services that will work in dealing with the issues of the community, within the community.

Thomas reported that, since he is continually advocating for better services for the Native American community, he was present at the last NTFAP meeting at which Mario Solis was also present. He reported that none of the Native American Community concerns were addressed. He stated that the fact remains – the Native American Community needs services desperately. What little services are available are haphazard, shoddy, and not visible in the community. He indicated that the NAAP is receiving well over $100,000 dollars to provided services, and he has not seen them produce anything for the Native American Community in the last several years. He added that it is disheartening to go continually to them and have people be mistreated, threatened and accosted verbally.

Ellen thanked everyone for their comments and asked if there was anyone else interested in speaking. There were none. Ellen facilitated the Council response to the public comment.

COUNCIL RESPONSE TO PUBLIC COMMENT & COMMUNITY CONCERNS

Maria Rinaldi referred to the third page, second paragraph, fifth sentence, of the anonymous letter sent to the HPPC. The sentence that stated that Proyecto had been part of Instituto Familiar de la Raza was an inaccurate statement. Proyecto was not a part of Instituto at any time. She then referred to the comments made by Diane Felix pertaining to the CURAS program. She explained that the CURAS program and the Shanti program had both suffered similar crises during 1991. However, Shanti remains, and CURAS disappeared. She expressed her belief that the communities of color did not and do not receive equal treatment compared to the white community. She indicated that it is her personal belief that ***all*** communities should receive ***at least*** equal services. [Note from the AO: Point of Clarification regarding CURAS; After repeated technical assistance and on-site organizational development from AO staff the organization was not able to survive and the AO therefore terminated their contracts. Regarding Shanti; After a thorough investigation it was determined that funds had been misappropriated. Shanti was required by law to re-pay the funds which the agency is now doing.]

Maria then addressed Luis Orozco. She observed that although she appreciates his comments, she does not agree that the HPPC is in any way jeopardizing itself. She is proud that the community -- whether anonymously or not – directed their complaints to this body. Although she does not approve of anonymous letters in general, the issue at hand is that there is a complaint that must be addressed by this Council. Her primary concern is not necessarily with the programs of the NTFAP or the NTFAP itself, but rather with the complaint that the Native American Community is not receiving services. If a community is not receiving services, then the HPPC must take some action to rectify the situation. She noted that, since the Council has been exposed to the two sides of this issue, it is imperative that they seek the truth in this matter. She explained that this is not about judging the NTFAP or any other agency, that is not in the purview of this Council. However, she is proposing that the Council take action to determine whether the services are being delivered or not. She explained that this is not about developing a plan to provide immediate services to the community, but rather a manner in which the Council can determine what is or is not being done in the Native American Community.

She indicated that, with the openness expressed by the members of the NTFAP, the Council might want to consider creating a committee to visit the programs that serve the Native American Community to determine first hand what services are being provided. This would allow the agency an opportunity to clarify any questions that might be circulating, and also possibly resolve the issues raised by the anonymous letter. The Committee could consist of HPPC members, AO staff and members of the Native American Community.

Elizabeth Davis expressed concerns about the NAAP. Her concern was so great that she recently took the opportunity to apply for the position of program director for the NAAP. She was very interested in providing the agency her expertise in HIV prevention. She indicated that she is a strong supporter of grass roots community based organizations and being a Native American, she also advocated for services to the Native American community. Elizabeth expressed that at the time of her visit to the NAAP, concerns were raised when she was not given clear answers after asking several questions pertaining to the types of services that were being provided to the Native American community. Being involved in many facets of the local community, she has failed to see or hear any Native American representation in the community meetings that she has attended. She would like to stand behind the NAAP. She addressed Darrell Joe indicating that she was very much interested in working with him and, if possible, she would be interested in volunteering her time to help with the program.

Bill Barnes noted that, being fairly new to San Francisco, he has never felt more like a person of color than since his arrival here. His experience on Capitol Hill was that a person would be judged by what they did. Since his arrival to San Francisco, any work, expertise and knowledge that he might possess has been negated by the fact that his father is black. Bill indicated that having worked with ACT UP Golden Gate and some of the accountability projects around the San Francisco AIDS Foundation (SFAF), he finds this situation with the NTFAP very interesting. He pointed out that, in the case of the SFAF accusations, the individual that made the accusations put his name on the line for his beliefs. Other organizations and individuals criticized him and talked about how the accusations were unfounded. In this situation with the NTFAP, an anonymous letter states accusations -- without anyone standing behind it – yet people are willing to continue deliberating over these issues. He indicated that it is interesting that some of the very people that have concerns with the SFAF criticisms apply different standards to the NTFAP situation.

Bill noted that personally he is not entirely certain that the services being provided to the communities of color by the NTFAP are competent. He referred to the comments made by Christopher Smith pertaining to the fact that there is only one agency that provides specific services for African American gay men in the entire city of San Francisco. He pointed out that in the white community there are multiple organizations

serving the many different sub-cultures of that community. It is not sufficient to say that one agency providing services to the African American community can meet all of the needs of that community. The conversation that the Council should be having is about where the gaps in services are and about recognizing that one agency can not possibly meet the needs of everyone in a given community. In closing Bill stated that he was also concerned with the fact that the NTFAP had not been notified by the Council regarding to the anonymous letter.

Jimmie indicated that it would have been his preference to be able to acknowledge the receipt of the anonymous letter that was addressed to the Council and its three Co-Chairs. Unfortunately, the letter did not provide the Council with any information that would enable them to do so. He admitted that he has had some concerns that the Native American community is not receiving a sufficient amount of services to address its needs. More specifically, the HPPC had recently identified a gap within the Native American community and funding was offered by the AO to provide specific interventions yet no one had applied for it. The gap remains. He is not validating the content of the anonymous letter, but he is asking that, in terms of overall services to the Native American community, there is a gap and regardless of who is providing or not providing the services, we need to find someone to provide the services, if current organizations are unwilling to do it. Jimmie asked if Mario would address why NTFAP did not apply for funding to serve Native Americans.

Mario Solis responded that the NTFAP had received the supplemental funding letter. The NTFAP had deliberated on how to complete the tasks that were being stipulated in the letter for the amount of funding that was being provided. He indicated that the pot of money that had been set aside for the Native American community was the smallest of all the funding made available. The organization took into consideration the fact that they were already providing more services than they could afford, and made the painful decision to pass on the opportunity. However, the NTFAP also realized that, by declining to participate, the funding level for other communities of color became more viable. The real issue for the organization was that it was already over taxed providing services to the Native American community with the current level of funding.

[Note from Tracey: The Native American AIDS Project was offered supplemental funds of $35,000 to $50,000 to reach all of the following populations: MSM and MSM/F Youth under 24 ($15,000 to $20,000); MSM and MSM/F ($10, 000 to $15,000); IDUs - male and female ($10,000 to $15,000).]

Mario indicated that there is a much broader issue here. Currently the City of San Francisco has a $80,000 to $90,000 contract with NAAP to provide HIV/AIDS prevention to the Native American community. He indicated that this is considered one of the largest single contracts for HIV/AIDS prevention for this community. Mario clarified that the NTFAP funding which was mentioned earlier – in the neighborhood of $100,000 – is strictly for CARE, and has nothing to do with outreach or prevention. Funding available for prevention in the Native American community is very limited. He noted that there have been some changes in the services that are allowable with prevention dollars, and therefore the visibility of some of the NTFAP programs has decreased. He stated that, although the current mode in San Francisco's planning process is moving towards less provider input and more consumer input, the planning process must continue to be aware of how their decisions affect providers. Mario stated that unfortunately providers are now being asked to provide higher units of service for less money. Although this Council is not here to talk about providers, but rather priorities, in order to reduce the rate of HIV transmission in our communities of color we must consider prioritizing dollars for these communities of color. [Note from Tracey: NAAP current contract for prevention is $135,363]

Maria addressed Mario and noted that the problem is that members of the Native American community fought tooth and nail to assure that their community's needs would be addressed with the supplemental funding, and yet the gap remains. The funding is there, and yet no one is providing the services. She realized that organizational issues might have prevented the NAAP to apply for this funding, but the fact remains that the needs of this community are not being met.

Chata noted that the responsibility of this Council is to the communities of the City of San Francisco. This Council should address the gaps in services within the communities, and also, acknowledge the concerns of the communities. These letters were not news to him. As Diane noted, rumors and allegations have been circulating within our community for some time. The question the Council needs to ask itself is how to separate rumor and innuendo from the truth. Since it is not within the Council's purview to investigate rumors and allegations, he suggested that the Council make a recommendation to AO and the Health Commission to initiate an investigation of these three programs to separate the hearsay and rumors from the truth. He stated that this is not about de-funding any programs, but rather about saving three local and viable programs that need to continue providing the very critical services to the Latino, African American and Native American communities.

Chata noted that there are many tools that are already in place -- such as the monitoring process, evaluations, assessments, Organizational Development and Technical Assistance – that could facilitate success for these agencies. He posed several questions to the program managers and to the DPH pertaining to the utilization of these tools. Are agencies actually utilizing these tools? When was the last time a program manager conducted a site visit in these agencies? Have the program managers participated in client services or spent time with outreach workers? Has that type of monitoring been conducted or is there simply an acceptance of the units of service with assumptions that needs are being addressed?

Chata added that the Shanti incident was not about units of service. It was about mismanagement and many other issues of accountability. He stated that the community must have a forum that allows them to express their grievances and concerns without fear of retaliation. It is the responsibility of the DPH and the Health Commission to ensure that services are being delivered to our communities in a culturally specific and appropriate manner. As an infected Indian who can not receive services in this City, he is appalled. He reiterated his suggestion that the Council make a recommendation to the DPH and Health Commission to conduct an investigation to separate the truths from the innuendo and hearsay.

Liz expressed her support of the decision of the Co-Chairs and DPH/AO to distribute these letters to the members of the Council. She disagreed with the concerns that they should not have distributed the letters. She agreed with Chata's comments that the responsibility of this Council is to the community. Liz added that as a journalist, she is aware of certain situations that would require a source to remain anonymous. She expressed her opposition to any act that would make the community feel that they could not come to this Council with their concerns. She noted that most individuals should understand that the fear of retaliation in small communities is a very real issue. That means that sometimes information must be delivered in an anonymous manner. She reiterated her support of the Co-Chairs and commended them and the DPH/AO for keeping the Council informed.

Jose Ramon indicated that he did not agree with the decision of the Co-Chairs and DPH/AO to distribute the anonymous letter. He explained that, if the authors was concerned about identifying themselves, they could have chosen another avenue to disseminate the information. He stated his belief that by distributing the letter the HPPC and the DPH/AO had endorsed its contents. Jose Ramon then asked for clarification as to whether Council held a contract monitoring function within its purview. He indicated that he was only

aware of the AO contract monitor who monitors his program. He did not see a need to create an HPPC committee to conduct site-visits on any program. It seems clear that this is the role of the AO.

Ellen clarified that the Roles and Responsibilities document states that the role of the HPPC is to set priorities for the City of San Francisco and to ensure that those priorities are met. The Council is not to allocate funds or administer funds or serve as the primary monitor of programs. However, there is a line in the Roles and Responsibilities document that allows the Council to participate in the monitoring process in order to ensure that the services which have been prioritized by the HPPC are being provided to the communities. As to why the letter was brought to this Council's attention, she explained that the HPPC also serves as a forum for community members to express their concerns.

Elizabeth made a motion *that the HPPC develop a task force to accept the invitation from the NAAP to visit their project to look at the services they are providing and then report back to the Council. There was a second.* Ellen opened the floor for Council discussion on the motion.

John West indicated that if the Council should decide to undertake this type of task force, then there should be a very thorough briefing by the Health Department. He also suggested that any monitoring documents that depict the monitoring efforts that have taken place over the last year and possibly longer should also be furnished to the task force. He expressed his preference that the HPPC not work independently on this task force, but rather it should be a collaborative effort between the Council and the DPH/AO.

Jimmie noted that, although he agrees with the idea of the motion, he suggested the implementation function would be that of the AO. If the AO wishes to investigate the NAAP and welcomes the Council's participation as part of their process, he supports it 100%. However, if it is taken on a separate function of the HPPC, then it may not be an investigation per say. The task force may wind up making recommendations, which is not within the Council's purview. He added that there is a need for action. However, it should not be the Council's primary function.

Colin urged the Council to move away from the use of 'investigation' as part of the language of this discussion. Although some aspects of finding out what is going on and why supplemental funding was not used would be useful, he asked that the concept of investigation should move towards a collaborative effort between the HPPC, the AO, the community and the agency in question, to work together to develop the skills and facilitate the ability to provide the services that are clearly a recognized gap.

Maria expressed her support of the motion and recommended that the HPPC also request that the task force developed be inclusive of AO staff, Council members and community members. The intent of the committee would be to determine what services are being provided or not. She reiterated that this would not be an investigation but rather a focused inquiry on the delivery of services to a particular community. There would not be any intentions to de-fund or recommend any type of implementation. If the inquiry should result in any such actions, it would be the sole responsibility of the AO and not the HPPC. Maria clarified that the Council should not focus on any specific agency, but rather on the specific services that were being provided or not.

Ellen summarized Maria's friendly amendment to the previous motion. The friendly amendment was: *to incorporate HPPC members, AO members, and Community members in the proposed task force.* Ellen also added that Barry Brinkley had offered a point of clarification that the monitoring function is a role of the AO. However, the AO has been and continues to be open to the idea of Council member participation in this process. Tracey noted that Elizabeth would have to accept or reject the friendly amendment made by Maria. Elizabeth restated her motion to include the friendly amendment.

Ellen regretfully noted that the Council was limited on the amount of time that they would be able to continue with this discussion. She noted that there were several other agenda items that needed to be discussed before the end of today's meeting. She requested that the Council include a few more comments on this issue before moving on to the next agenda items.

Barry noted that the AO has an on-going process for monitoring all of the contracts with community based organizations that provide prevention services. He indicated that the AO would like to make it very clear that it is their responsibility to provide that monitoring process. The AO sees this monitoring process as a partnership, and therefore they welcome participation from members of the HPPC, without conflict of interest, to participate in that on-going process. He reiterated that the conceptualization of a task force to specifically address this issue falls within the purview of the AO. The Council's responsibility for accountability on behalf of the community would fall under the AO on-going monitoring process. He added that it is the role and responsibility of the AO and the program managers to work with the monitoring team to go out and conduct any type of monitoring process follow-up.

Barry stated that, in terms of the service gaps in Native American community, any agency that is receiving funding to provide said services but is not doing so is by definition out-of compliance with their contract. This issue would be addressed by the AO and its monitoring team. Barry indicated that the current on-going monitoring process which is used by the AO may also be used to provide this body with follow-up information on these issues. He recognized the concerns of the Council to address these issues, and indicated that, since there is already a mechanism in place, the AO monitoring process, he would recommend that the most effective venue would be for the AO monitoring team to conduct a follow-up and then report back to the HPPC. Maria asked whether the monitoring team follow-up would include HPPC members. Barry responded that it is not unusual for Council members to participate in the monitoring process. In fact HPPC member participation in the monitoring process provides member access to the provider community at large. [Note from Tracey: The HPPC goals and objectives for 1997 specify that the AO will include HPPC members on prevention monitoring teams.]

Norm Nickens reiterated that one of the roles of the AO was to conduct on-going monitoring of all community based organizations that are funded for prevention, as well as CARE, through the DPH/AO. He reported that all of the monitoring reports are public documents that are available to anyone interested in reading them. The act of forming a joint task force of HPPC members and AO staff to investigate the allegations of these letters is not within the purview of this planning body. However, if the HPPC wishes to hold a discussion about the adequacy of services within a specific community, they could invite the agencies that provide the services to said community to conduct a public forum to discuss those issues. As far as HPPC involvement in the monitoring process, there is a selection process to identify eligible members. Members would have to be knowledgeable about the specific service area and be free of any conflict of interest. Although the AO welcomes HPPC involvement, the Council does not have the authority to initiate a monitoring investigation.

Ellen reiterated what both Barry and Norm had said regarding the on-going monitoring process of the Health Department. She noted that there was an interest on behalf of certain Council members to recommend that the monitoring process occur with a particular focus on the HIV prevention services to the Native American community. And also there was a request that Council members participate in that process. She explained that it is clearly in the purview of the AO to grant or reject this request. However, let it be duly noted that the request was made.

Ellen then summarized that a motion and a second had been made, that were then followed by a friendly amendment. The DPH/AO had then provided a point of clarification that indicated that the motion would not be within the purview of this Council and therefore the motion and the friendly amendment would both have to be retracted. Maria expressed her confusion as to the need to retract the motions. She indicated that the Roles and Responsibilities document is not clear about this specific issue and whether or not it is within the Council's purview. She noted that it is clear that the HPPC does not have a purview in investigating or monitoring any agency. The Roles and Responsibilities Document states that the HPPC does have a purview in investigating whether or not services for a particular community are provided within that community. Maria stated that it is her preference that the intent of the motion is not agency specific but rather about developing a task force that will undertake the task of determining whether the services are in place or not.

On behalf of the Co-Chairs Ellen asked for a two minute caucus to determine what was feasible and within the purview of this Council as well as the parliamentary process to complete actions on the floor. Ellen reconvened the meeting and asked that Elizabeth summarize the clarified motions. Elizabeth stated the following:

- *The HPPC respectfully requests to be invited to the monitoring process of the local programs of the NTFAP, and*
- *That a needs assessment be conducted by the Council with the assistance of the AO for HIV prevention services for gay men of color irrespective of agencies.*

Ellen then called on Mario who reiterated the invitation to the Council from the NTFAP. Mario indicated that the NTFAP is very proud of what they are accomplishing and looks forward to working with the HPPC and its Co-Chairs to schedule a possible visit to the agency by Council members.

Ellen summarized that the two motions, as well as the invitation from the NTFAP, could potentially address the multiple concerns that were being discussed by the Council. Tracey noted that prior to any continued discussion on these new motions, both Elizabeth and Maria would need to retract their initial motions. Elizabeth withdrew her motion and Maria indicated that she would also withdraw her initial amendment to Elizabeth's motion with the stipulation that the AO would agree to include HPPC members in their monitoring process of the local programs of the NTFAP. Ellen indicated that the AO had indeed extended such an invitation to the Council. Both previous motions were withdrawn.

Helen Miramontes called for a point of order regarding the current meeting process. She expressed her frustration at having heard several different variations of the motions and requested a reiteration of the current motion. She also suggested that in order to avoid this confusion in the future individuals should document the specific language of their motions.

Amalia read the first motion and a second was made. Ellen asked if there was any Council discussion, and there was none. Ellen facilitated the vote.

In favor:	15
Opposed:	0
Abstained:	2

The motion was approved.

Amalia read the second motion and a second was made. Ellen asked if there was any Council discussion. John West asked for clarification as to whether it was within the Council's purview to initiate a needs assessment. Ellen responded that this was listed in the Roles and Responsibilities document as one of the shared responsibilities of the AO and the HPPC. Jennifer asked when the last time such an assessment had been conducted. Tracey responded that the last assessment had been conducted during the development of the Plan in 1994. Ellen asked if there were any other comments. There were none. Ellen facilitated the vote.

In favor:	14
Opposed:	0
Abstained:	3

The motion was approved.

Ellen indicated that the last issue to be addressed was the invitation from the NTFAP. Mario quickly reiterated his invitation and then Ellen asked for a show of hands to determine if the Council was supportive of the idea of visiting the NTFAP local programs.

In favor:	15
Opposed:	0
Abstained:	2

Ellen summarized that the Council supports the idea of visiting the NTFAP local programs.

Ellen thanked everyone for their participation and closed this order of business. Ellen reminded everyone to complete the evaluation on the first half of the meeting, and noted that the Assessment Committee had agreed to postpone their presentation to allow the Linkages Committee the opportunity to complete their presentation. Given the additional time taken by the public comment and discussion, the Co-Chairs and the Committees negotiated this adjustment to the agenda. Ellen noted that the Co-Chairs would be discussing the logistics of the needs assessment at their next meeting, and would request volunteers to participate in developing it at future Council meetings.

BREAK

4. LINKAGES COMMITTEE - CULTURAL COMPETENCY TOOL (FINAL VOTE)

Ellen introduced the Linkages Committee. Sacul greeted everyone and introduced her Committee co-member Sonja for the presentation on the Linkages Committee Cultural Competency tool. She noted that she had requested that Tracey facilitate any Council discussion.

Sonja reported that this would be the last in a series of presentations by the Linkages Committee. She indicated that the Cultural Competency Tool which was being distributed was the Committee's final product. She stated that at the last presentation to the Council, the Committee had requested specific feedback from Council members on whether or not the tool was too much to ask agencies to complete. Gratefully, the Council had indicated that it was not.

Sonja then summarized that the only changes to the tool were the inclusion of two open-ended questions at the end of the tool. She referred to the seventh page of the tool and to questions ten and eleven.

- What efforts does your agency take to ensure its cultural competency? And,

- How well do you feel this tool helped to assess your agency's cultural competency? Please explain.

Sonja explained that the Committee had also discussed and developed several recommendations for the next years Committee, regarding:

- Development of criteria for reviewers.
- Incorporation of the tool in the monitoring process.
- On-going evaluation of the tool – particularly once it has been used with RFP's
- Pilot testing the tool – perhaps with next years RFP.
- Client based surveys to evaluate agencies' cultural competency.
- Media/Press release to introduce to the tool to the community.

Tracey clarified that this presentation from the Linkages Committee was a motion for *Council acceptance of this tool as a final document, with the six proposed recommendations and the knowledge that its implementation would be developed at a later date.* A second was made. Tracey indicated that public comment during agenda items such as this would be conducted for ten minutes after the Council discussion. Tracey then opened the floor for Council discussion.

Bill expressed his support of the tool. Jimmie noted a general concern pertaining to the misinterpretation of agency versus program. He pointed out that previous clarification indicates that each program and/or collaborative would have to complete this tool in relation to their specific program. Jimmie reiterated his previous recommendation that the Committee revise the language in the tool to consistently reflect 'programs' rather than 'agency.'

Jennifer stated that the tool looked great. She noted that from a provider's perspective however, she would recommend that the Committee consider adding a definition of Cultural Competency. Sacul responded that the Committee had developed an introduction that would be attached to the tool in which a definition was provided. Tracey opened the discussion for public participation.

Hank Wilson expressed his belief that this tool would be very helpful. He referred to a comment that was previously made which suggested on-site visits in addition to this tool when assessing a program's cultural competency. Hank stated that it is not uncommon for programs to solicit the aid of skilled writers to respond to documents such as this. A site visit would provide a crucial dimension in assessing a program's cultural competency. Sonja indicated that for that very reason the Committee had discussed the need to recommend that the tool be incorporated in the AO monitoring process.

Christopher Smith noted that the tool would be beneficial in assessing cultural competency in that it allows providers to look critically at themselves. However, he was curious about who would be asked to complete the tool -- the management staff or the front line staff. Sacul responded that the Committee had not wanted to dictate who would be completing the tool. She indicated that she did not foresee a problem with the idea of suggesting that the tool be completed by all members of a program. Jimmie stated that site visits that had been recommended would potentially address that concern, since the intent of the site visit would be to determine and validate whether the responses to the tool are accurate.

Barbara expressed her support of the tool and indicated that she agrees that the tool should also be included with the monitoring process. Maria stated that the tool was great and recommended that tool be used with RFPs, the AO monitoring process, site visits and prior to any type of funding allocation.

Chata commended the Linkages Committee for its work, but more specifically he commended Sacul for her leadership and strength during the year in what was a very difficult and complex discussion. He also acknowledged all of the people who took time to participate in the development process of the tool. Sacul thanked Chata and commended him for all of his work with the Committee.

Jelousy expressed his support of the document. He stated that, when discussing site visits, the Council should also consider conducting site visits with the outreach staff as well. Kiki Whitlock asked whether it had yet been determined how much weight would be given to Cultural Competency and this tool within the RFP process. Tracey responded that although a very important question, the implementation phase of the tool has not yet been determined.

Tracey reiterated the motion: *Council acceptance of this tool as a final document, with the six proposed recommendations and the knowledge that the implementation would be developed at a later date.* She noted that a second had been made and asked if there were any other comments. There were none. Tracey facilitated the vote.

In favor:	17
Opposed:	0
Abstained:	0

The motion was unanimously approved. Tracey thanked the Committee members and all of the technical support staff that worked with the Committee to provide the Council with this tool. Sacul thanked everyone for their support and extended a special thanks to Rick Green and Delia Garcia.

5. CLOSURE/EVALUATION AND BACKGROUND SURVEY

Ellen introduce Kathleen Roe of the Process Evaluation Team. Kathleen quickly summarized the topics that she would be discussing. She informed the New Member Committee that the Process Evaluation Team was available to attend any of their future meetings in order to provide a more detailed outline of the task and intent of the Process Evaluation team.

She briefly explained that the Centers for Disease Control (CDC) -- which funds the community planning efforts – has required that community planning process be evaluated. This component of the planning process is well funded. She explained that process evaluation is not the same as outcome evaluation. Unlike outcome evaluation, the process evaluation is a collaborative effort that provides its recommendations and feedback throughout the planning process. The process evaluation component includes participation from the team during all aspects of the planning process: meetings, committees, debriefings, etc. The only aspect in which the team does not participate in is voting. The goal of the process evaluation team is to facilitate the community planning process. On a daily basis the team helps to guide the planning process. It supports the stronger areas of the process, or makes suggestions pertaining to areas that may be suffering. Kathleen noted that there are three principles that the CDC has specified in their guidance. These three principle of the community planning process must be evaluated by the process evaluation team. The three principles are:

PIR

Parity *- Equal opportunity for input and participation; equal voice in decision making.*
Inclusion *- Meaningful representation and involvement of all affected communities.*
Representation *- Those who represent a specific community must truly reflect that community's values, norms and behaviors.*

The process evaluation team examines the adherence of the HPPC to these principles. The team works with the HPPC Co-Chairs, Committee Chairs and individual Council members to guarantee that these principles are followed. She explained that the forms that are given to all Council members at each Council meeting provide the process evaluation team with feedback that is then used to report back to the people who are monitoring and managing this process. The forms are designed to bring forward the views and perceptions of the Council members pertaining to the three principles -- Parity, Inclusion and Representation – as they relate to this planning process.

Kathleen then explained the process evaluation forms. Referring to the 'dialogue boxes' form, she explained that these boxes had been pioneered in Alameda County, and had proven to be very effective. The intent of the boxes is to allow members an opportunity to say things that, for whatever reason, they were unable to express during the meeting. Council members are also asked to complete the regular meeting evaluation form. This questionnaire is designed to serve a dual purpose. The first is to capture the perspective of Council members pertaining to the meeting process. The second is to remind presenters that this Council has specific expectations of the manner in which the Council meetings are conducted. Although these questions are not necessarily neutral, they do provide presenters some sense of what is expected of them. This form also includes space for comments. The process evaluation team encourages all members to use this space. The team documents all that is written by members, and follows up by providing a detailed copy of the results at subsequent meetings.

The process evaluation team attends the HPPC meetings, the Co-Chairs meetings, the various Committee meetings, and the Steering Committee meetings. The team is also available to meet one on one with individual members either formally or informally. Another aspect of the process evaluation is the occasional exercises that provides an immediate sense of the Council's position on a given discussion or meeting. Kathleen then initiated one such exercise entitled 'Three Words'. The Council members briefly completed the form which was distributed to them and then each member shared one of their three words with the rest of the Council.

The last topic discussed was the supplemental funding evaluation report status. The process evaluation team had been able to interview all but one of the funded applicants. She explained that once the last interview was completed the process evaluation team would provide the Council with a final written report. The other aspect of the supplemental funding process evaluation is to contact all of the agencies that had been invited to apply for funding, but had chosen to not apply. The results from those interviews would be presented to the Council in a subsequent Council meeting.

Ellen thanked everyone for their participation and asked that members complete their evaluation forms before leaving.

Attached to these minutes for absent members:

- DPH Letter dated December 10, 1997 from Norm Nickens, pertaining to the correspondence addressed to the HPPC.
- New Members – Mentor Matches phone list.
- Process Evaluation Results and Participant Dialogue boxes from the November 20 meeting.
- Cultural Competency Assessment Tool, dated December 8, 1997

Minutes Recorded by: Amalia Fernandez-Niewendorp, Polaris R & D, Inc.
Minutes Approved by: Ellen Goldstein, Community Co-Chair and Tracey Packer, DPH Co-Chair

HIV PREVENTION PLANNING COUNCIL MEETING

DECEMBER 18, 1997
3:00 PM to 5:00 PM
First Unitarian Church
1187 Franklin Street (@ Geary)
San Francisco

Meeting called by: **Co-Chairs:**
Ronnie Ashley (Chata)
Ellen Goldstein
Tracey Packer

AMENDED AGENDA

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1. Welcome/Introductions/Announcements	Chata	3:00 - 3:10 PM
2. Rescind Actions of 12/11/97 re: NTFAP and Reintroduce Motions (Vote) *[Procedural Clarification]*	Ellen Goldstein	3:10 - 3:20 PM
3. Transgender Community Health Project (TCHP) Update	TCHP Team	3:20 - 4:20 PM
4. End of Year Summary	Ellen Goldsteing	4:20 - 4:30 PM
5. Evaluation	Chata	4:30 - 4:35 PM
6. Member Recognition and End-of-Year Celebration	All	4:35 - 5:00 PM

Upcoming Meetings

HPPC Meeting - Thursday, **January 8, 1998, 3-6** PM, First Unitarian Church 1187 Franklin Street (@ Geary)
HPPC Meeting - Thursday, **January 22, 1998, 3-5** PM, First Unitarian Church 1187 Franklin Street (@ Geary)

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HIV PREVENTION PLANNING COUNCIL (HPPC)
Minutes for December 18, 1997

* Please note in your calendar any of the following meeting times that apply to you: *

HPPC:	Thurs., Jan. 8, 3-6 p.m. at the First Unitarian Church
	Thurs., Jan. 22, 3-5 p.m. at the First Unitarian Church
Evaluation Committee:	Mon., Jan. 5, 4-6 p.m. at the AIDS Office
New Member Orientation:	Thurs., Jan. 15, 1998, 3-5 p.m. at the AIDS Office
	Thurs., Jan. 29, 1998, 3-5 p.m. at the AIDS Office

Members Present:
Barbara Adler
Ronnie (Chata) Ashley
Marcos Bañales
Manny Dacalanio
Michael Discepola
Ellen Goldstein
Liz Highleyman
Jelousy Jiggetts
Valerie Kegebein
Sacul L'Adnbre
Jennifer Lorvick
Sonja Mackenzie
Askia Muhammad
John Newmeyer
Shawn O'Hearn
Henry Ocampo
Tracey Packer
J. Colin Partridge
Dawn Passar
Jeff Polil
María Rinaldi
Steven Sams
Nashanta Stanley
Steven Tierney
John Blake West

Members Absent:
Bill Barnes
Michael Bogan
Elizabeth Davis
Brenda Escobar
José Ramon Fernandez-Peña
Dave Hubbard
Dredge Byung'chu Kang
Byron Mason
Helen Miramontes
Jimmie Naritomi
Renee Williams
A. Toni Young

AIDS Office Staff:
Barry Brinkley
Kristen Clements
Delia Garcia
Marshia Herring
Mike Pendo

Guests:
Ari Bachrach, TCHP - AO
Nikki Calma, TCHP - AO
Tamara Ching, Southeast Asian Community Center
Carla Clynes, TCHP - AO
Rob Guzman, TCHP - AO
Scott Ikeda, TCHP - AO
Cynthia Laird, Bay Area Reporter
Matt Rice, TCHP - AO
Doan Thai, TCHP - AO
Stacy Vogan, STD/HIV Prevention Training Center
Hank Wilson, ACT UP Golden Gate

Harder + Co./Polaris, Inc.:
Amalia Fernandez-Niewendorp, Polaris Inc.
Martin Forst, Polaris Inc.
Rick Green, Harder + Co
Lyn Paleo, Harder + Co.

Process Evaluation Team:
Pali Basi
Ruel Caneda
Kathleen Roe
Kevin Roe

1. FOOD, WELCOME, INTRODUCTIONS, AND ANNOUNCEMENTS

Chata convened the meeting shortly after 3:00 p.m. He welcomed everyone, and asked that all members and guests introduce themselves. He asked if there were any announcements.

Announcements

Member Absences

- The following individuals had informed the Co-Chairs of their absence from today's meeting: Elizabeth Davis, Brenda Escobar, Helen Miramontes and Jimmie Naritomi.

2. REVIEW AMENDED AGENDA #2

Tracey began by offering the Council an apology for the last minute agenda changes. She pointed out that copies of the final agenda were available at the back table. She explained that as a result of the discussions and consequent votes that occurred at the 12/11 Council meeting, a concerned participant of that meeting contacted the City Attorney's office. The individual inquired whether the Council was operating appropriately and in accordance with the Brown Act. Tracey briefly summarized the concern raised pertained to the requirement under the Brown Act that any issues that are to be discussed and voted upon

must be listed as an agenda item. In addition, the agenda must be publicized at least 72 hours prior to the meeting date.

Tracey explained that when the Council was first developed , it was determined that the Brown Act did not apply to the HPPC. The reasons that it was assessed that the Brown Act does not apply to this Council are: The HPPC is not appointed by a statute. It is authorized by the Centers for Disease Control. And secondly, the members of this Council are not appointed by an elected official. Members are appointed by the Director of Public Health, which is not an elected position. Tracey reported that the City Attorney's office had advised the Co-Chairs to take certain measures to rectify any inappropriateness on behalf of the Council, while they made a determination about the Brown Act. The Co-Chairs were informed that they should take immediate action to rectify the problem and therefore faxed members the first amended agenda. After further deliberation the Co-Chairs agreed to continue operating as they had been for the last four years, resulting in this third (and last) agenda. When the Co-Chairs receive a final official decision from the City Attorney's office the Council will be notified.

John West suggested that it might be useful to provide the Council with a presentation on the procedures used by the DPH to respond to allegations of improprieties. Tracey thanked John for the suggestion and indicated that she would try to accommodate his request in the earlier part of next year.

Maria commended the Co-Chairs for their immediate action to resolve the situation. She recommended that in order to make better use of this Council's time, participants aware of any such improprieties inform the Council immediately in order to avoid unnecessary deliberations.

Tracey thanked the Assessment Committee for having deferred their scheduled presentation until January 1998. She explained that because of the amount of time that had been spent on the public comment section of the 12/11 meeting, presentation form the Assessment Committee had not occurred.

3. TRANSGENDER COMMUNITY HEALTH PROJECT (TCHP) UPDATE

Chata welcomed and introduced the TCHP staff. He explained that the "buzz" around the community this last year has been about the enormous amount of work and dedication that the individuals from the TCHP have provided for the community.

Kristen Clements explained that this project had been prioritized by the HPPC because there was very little data on this population. There was also reason to believe that the Transgender Community was a high-risk population and one that was not being adequately served. She reported that two years ago AO staff and many members from the Transgender community conducted a series of eleven focus groups with the intent of gathering formative information that would provide a better understanding of this population. Kristen indicated that copies of the report from these eleven focus groups were available at the back table.

She noted that this TCHP update pertained to a quantitative study conducted by the project in collaboration with the Community Advisory Board. The TCHP team began collecting data July 1, 1997 and Kristen indicated that the team would be completing their data collection later this month. She then introduced the TCHP team for the presentation.

(The Transgender Community Health Project presentation included a series of detailed overheads which are attached to these minutes for all members. Please refer to the attached copies of the overheads for more in-depth information pertaining to the topics presented.)

Nikki Calma referred to the *Basic Vocabulary* overhead ***(Attachment No. 1 - page 3)*** and explained that this vocabulary would be used throughout the TCHP presentation. Scott Ikeda reported that the overall goal of the study was to assess whether the transgender community was at an increased risk of contracting HIV. He indicated that the TCHP hoped that the results from this study would be used to guide future health services and prevention efforts. Scott then described the *Study Objectives, Study Overview, Interview Sites and Staff Training* process ***(Attachment No. 1 - pages 4 to 8).***

Rob Guzman reviewed the *Screening Process, Appointment Criteria, and the Preliminary Findings* of the study that were broken down by: *Appointments, Race/Ethnicity, Primary Gender Identification, Gender Identification by MTF and FTM, and Seroprevalence* ***(Attachment No. 1 - pages 9 to 15).*** Nashanta Stanley summarized the projects *Interview and Counseling Sessions Challenges, Peer-Based Counseling Approach, and the Service Availability* ***(Attachment No. 1 - pages 16 to 19).***for the transgender population. Next Nikki Calma reported on the extensive recruitment process undertaken by the TCHP at the Motherlode. Nikki summarized the background information on the *Motherlode, the population which frequents the site and some of the aspects of the recruitment at this site* ***(Attachment No. 1 - pages 20 to 23)..***

The next part of the presentation pertained to the specific sub-communities within the Transgender population. Presenters Doan Thai, Carla Clynes, and Matt Rice reported on the *Recruitment and Prevention barriers, the specific Risks for the sub-community, and Health Service Needs of the sub-community.* The three sub-communities discussed were: *Asian Pacific Islander, Latino/a, and Female to Male (FTM)* ***(Attachment No. 1 - pages 24 to 36).***

Ari Bachrach finished the presentation with a summary of the referral process. Ari discussed the *Referral Problems* and the *Solutions* ***(Attachment No. 1 - page 38)*** the team developed to deal with these problems. Ari also explained how the *Referral Process Worked,* and the *Most Common Referrals that were accommodated by the TCHP and those that could not be accommodated by the TCHP* ***(Attachment No. 1 - pages 39 to 41).***

Kristen reiterated that most of the data presented today was preliminary and not final data from the study. This preliminary information is, however, reflective of the focus group findings and will probably be reflective in the final quantitative study report. On behalf of the TCHP she offered to return to provide the Council a presentation of the final quantitative findings of this study. Kristen then facilitated the Council response to the presentation.

The Council complemented all of the presenters and praised them for the clarity and precision of the presentation. In response to one Council member's question, Nashanta stated that the primary needs of many of the clients were not HIV related, but rather had to do with other issues such as primary health issues, homelessness, and other 'survival' type needs.

Kristen regretfully noted that they were out of time. She reiterated the project's offer to return to the Council in the coming year. She added that the TCHP team would be completing the study in the next month, and therefore they would be available to answer any questions that Council members might have.

Kathleen Roe noted that although there was not a specific dialogue box for the Transgender Community Health Project, she encouraged Council members to list any comments to the team in any of the four dialogue boxes. The process evaluation team will then forward the information and comments to the project.

4. PROCESS EVALUATION REPORT: MEMBER BACKGROUND EXPERIENCE

Chata introduced Kathleen Roe from the Process Evaluation team. Kathleen noted that on behalf of the Co-Chairs, the process evaluation team was distributing an additional evaluation form. The form asks members to list specific feedback and ideas for future Council meeting trainings, discussions or presentations. Members may request specific interventions, populations, outreach methods, strategies, or other prevention-related topics that would be of interest and benefit to the Council. The presentation given by the TCHP would be a perfect example of the types of presentations that could be listed. This type of presentation educates the Council which then fosters well-informed decisions. She noted that these forms will also be made available to Council members at future meetings.

Kathleen then presented the findings of the HPPC Member Background Experiences surveys. She noted that the process evaluation team received 25 completed surveys. Anyone who did not receive or complete the survey may request a copy from the Process Evaluation team. Once completed, the team will incorporate it into the existing findings. She noted that the results of this survey will be useful when thinking about the needs of this Council for next year. These results demonstrate the assets, expertise, and strengths of each of the Council members as well as the areas that require some attention. She stated that these results represent the 1998 HPPC Council. Two items were distributed: a copy of all of the survey data that was collected and a copy of the overheads that Kathleen would be discussing. *(Copy attached to these minutes for all members - Attachment No. 2, Pages 1 through 4.)*

Kathleen explained that for the purpose of the presentation she had categorized the findings into several boxes. She referred to the first page of the overhead handout. The first box lists the areas in which the Council has a great deal of experience in. The findings reflect that the Council is very familiar with the epidemic and that a large proportion (71%) of the Council members have a great deal of expertise in working with productive large groups and decision-making. This will be a tremendous asset for the Council in that it will help to facilitate the planning process. The other box lists the areas that the Council has less expertise in. Kathleen noted that although this is not necessarily a negative indication, Kathleen suggests that these are possible areas that the Council might want to bring in outside speakers/trainers to address. The Council should also keep these areas in mind when selecting and recommending new members.

Kathleen pointed out that half of the Council does not have experience reviewing grants proposals. Since the Council will be looking at the review process in preparation for the future RFP (1999), it might be important to request a specific training piece to bring everyone up to speed. Another important area that seems to require some attention is the limited experience in monitoring/evaluating cultural competency.

Kathleen referred to the next two pages of the overhead handout. The data were listed by specific areas concerning the type of work that the Council will be addressing next year. She pointed out that there was a clear need for some type of training around monitoring/evaluation of cultural competency of programs and agencies. Kathleen noted that attention should also be paid to the limited experience of this Council pertaining to Robert's Rules (parliamentary procedures.) Since 60% of the members have some or no experience in this area, the Council might consider conducting a relevant training. This is a crucial component of the planning process. When the Council faces votes on important or controversial issues, members should not be struggling with issues about rules and procedures.

Kathleen then noted that there was a resource of members with press and media backgrounds. She suggested that the Council might consider some sort of media advocacy project that would provide accurate and broader coverage of the HPPC work. Another really good resource is the Council's public speaking

the Council begins to bring the community into the process. Kathleen quickly reviewed the results of the members open-ended responses. (The last two boxes of the handout.) She asked if there were any questions or comments. There were none.

5. EVALUATION

Chata thanked everyone for their participation and asked that members take a moment to complete their evaluation forms.

6. MEMBERS RECOGNITION AND END-OF-YEAR CELEBRATION

The Co-Chairs distributed certificates of appreciation to all Council members and HPPC consultants. The Council was also gifted with a traditional Native American drum ritual.

Attached to these minutes for all members:

- Attachment No. 1: San Francisco DPH - AO Transgender Community Health Project presentation overheads.
- Attachment No. 2: Process Evaluation HPPC Members Background Experiences results presentation overheads.
- Good-bye Letter from Liz Highleyman, dated 12/18/97

Attached to these minutes for absent members:

- Amended Agenda #2
- Process Evaluation Results, Participant Dialogue boxes, and Three Words exercise results, from the 12/11 Council meeting.
- Process Evaluation HPPC Members Background Experiences results.
- "HIV Prevention & Health Services Needs of the Transgender Community in San Francisco: Results from Eleven Focus Groups," San Francisco DPH - AO, 1997.

Minutes Recorded by: Amalia Fernandez-Niewendorp, Polaris R & D, Inc.
Minutes Approved by: Ellen Goldstein, Community Co-Chair and Tracey Packer, DPH Co-Chair.

Attachment No. 1

"San Francisco DPH - AO Transgender Community Health Project Presentation Overheads."
Pages 1 through 41



San Francisco Department of Public Health, AIDS Office

Transgender Community Health Project

TG 101

Basic Vocabulary

- **Transgender** - is an umbrella term which describes different types of gender identities or gender expressions.
- **Transsexual(TS) -** A transexual person *identifies* and *desires* to be of the other sex.
- **Transvestite(TV) -** People who wear clothing normally associated with the opposite gender for emotional comfort or sexual pleasure
- **Intersexed -** People born with ambigious genitalia and/or sex chromosomes.
- **M T F** - Male to Female
- **F T M -** Female to Male
- **Gender Identity and Sexual Orientation are different**

Transgender Community Health Project

Study Design

Study objectives, methods, collaboration, and staff training

Study Objectives

- Sociodemographics, health status, access to prevention/health services
- Prevalence of HIV risk behaviors
- HIV Seroprevalence
- Association between specific behaviors and HIV Seroprevalence
- Differences among sub-populations
- Linking participants with prevention, health & social services

Study Overview

- Cross-sectional quantitative study
- 500 participants (mix of FTM and MTF)
- Standardized face to face interview
- HIV testing and counseling
- Five interviewers hired from the community
- Six months recruitment time
- Targeted recruitment at agencies & venues frequented by community members
- Snowball referrals

Interview Sites

- Asian/Pacific Islander Wellness Center
- Proyecto ContraSIDA Por Vida
- New Village
- Center for Special Problems
- Glide/Goodlett HIV Program
- Instituto Familiar de la Raza
- Tom Waddell Clinic
- SFDPH AIDS Office

Staff Training

30+ Trainings:

- Study instruments, methods, protocols
- HIV 101, 202, 303...
- General health/social services
- Culturally specific trainings

Screening

- 1-800 #
- Eligibility questions
- Appointment scheduled for preferred site, interviewer
- Assigned unique ID number

Appointment

- In person screening
- 45-60 minute interview
- 15 minute counseling
- OraSure specimen collection
- $40 stipend
- Referrals
- Snowball cards
- Follow up scheduling

Preliminary Findings Appointments

- 620 screened
- 598 eligible and scheduled
- 531 (89%) showed for appointment
  - 509 (96%) Eligible and completed survey
  - 22 (4%) Not eligible at 2nd screening
- 345/474 (73%) returned for follow up

Preliminary Findings Race/Ethnicity

- White 36%
- African American 25%
- Latino 21%
- Asian or Pacific Islander 8%
- Native American 6%
- Other 4%

(N=463)

Preliminary Findings Primary Gender ID

- Transgender 36%
- Female 29%
- Transsexual 22%
- Male 9%
- Third Gender 2%
- Intersex 1%
- Transvestite <1%
- Androgynous <1%

(N=463)

Preliminary Findings Gender ID by MTF, FTM

MTF (N=338)	
73% of sample	
Transgender	50%
Transsexual	44%
Cross-Dresser	3%
Third Gender	1%
Transvestite	1%

FTM (N=118)	
25% of sample	
Transgender	46%
Transsexual	48%
Third Gender	6%

Preliminary Findings Seroprevalence

Overall: 29%, N=469

- MTF: 30.6%, n=108
- FTM: 2.7%, n=39

Transgender Community Health Project

Counseling and Interviews

Peer-Based Approach, Counseling Challenges & Service Availability

Interview & Counseling Sessions

- Clients were often in crisis
- Clients' priority issues-not HIV
- Clients' issues "close to home"
- Many clients had not accessed ANY form of services prior to interview
- Many clients were high risk and were testing positive for HIV

Peer-Based Approach

- Peer-based approach helped us build trust
- TCHP staff acted as positive role models
- Most clients felt more comfortable with someone who understood their issues
- When clients were hesitant of peers conducting interviews, we had options

Services Availability

- Clients had little information on HIV prevention/services prior to the interview
- Clients had negative experiences with services that were not “trans-sensitive”
- We were research associates, not direct service providers
- What clients really needed was a case mananager / client advocate

Transgender Community Health Project

THE MOTHERLODE

The Motherlode

- Situated in the heart of the Tenderloin, this particular group lives & socializes in this area.
- Predominantly frequented by MTF TG folks who do sex work and their admirers(e.g. “johns”/paying customers), consists mostly of heterosexual men who still believe they are not affected by HIV/STD.
- Sex work in the surrounding area. Police visibility has created tension between the community and the police, constraining outreach and prevention work with the community.
- Prevalence of recreational drugs such as speed & crystal meth in the community due to its sex work. Both injection and non-injection.
- Accessibility and use of black market hormones.

The Population

- Mostly local MtF sex workers; TG folks who are "pros" - travel from one state to another to do sex work.
- HIV testing is a big issue due to their sex work.
- RISKS
  -Unprotected Sex
  -Drug Use
  -Black market hormones, specifically intramuscular hormones.
- Most of these folks are unaware of social services that are available to them.
- Very culturally diverse population.

Recruitment

- Establishing a very good relationship with owner/staff of the club.
- Extensive flyer/outreach distribution by TCHP staff. TCHP staff consistently is visible with in the community and its environment to build trust and confidence.
- Providing what the community needs (e.g. Kiss of Mint condoms, lubricant). Awareness of community's issues and concerns.
- Referrals to different CBO's that serve the TG population, if needed.

Transgender Community Health Project

Asian / Pacific Islander Population

Recruitment, Risk, Prevention and Services

Recruitment



- Past experience with disclosure of HIV status
- Language Capacity
- Afraid of testing
- Need time to build trust



Risk

- Sex work and street lifestyle
- Low self-esteem
- Economic necessity, lack of education
- Connection between substance use, sex work and unsafe behavior
- Little or no knowledge about HIV & STDs

Prevention & Health Service needs

- Language barriers
- Unaware of available services
- Discrimination
- Mistrust of agencies
- Prop 187 and immigration status

Transgender Community Health Project

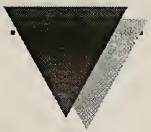
Latino/a Transgenders

Recruitment, Risk, and Prevention

Recruitment

- Monolingual Spanish speaking transgenders
- Confidentiality
- Fear of HIV testing
- Outreach
  - on the streets
  - bars
  - under the bridges
  - silicone parties
  - sex clubs
- Latino FTMs even more isolated

Risk



- **Sex work, drug use and unsafe sex**
  - more money for sex without condoms
  - more money for drugs and sex together
  - exchanging partners under the bridges when high
  - use of speed and cocaine to try to make more money
- **Needle sharing**
  - recreational drugs
  - hormones
  - silicone



Prevention

- **Language barriers**
  - information that is not Latina Transgender specific is not effective
- **Cultural barriers**
  - "real Latina women do whatever the man wants"
- **Economic necessity**
  - drug use and unprotected sex = more money
- **TransProtection**

Transgender Community Health Project

FTMs

Recruitment, Risk, Prevention and Services

Recruitment

- No bars where FTMs hang out
- Benefits and events
- FTM International meetings
- Site based
- Film festivals
- FTM Conference
- Internet email lists
- Letters to FTM Int'l mailing list
- Confidentiality in small communities

Risk

- FTMs who have sex with other queer men
- Barriers to using barriers
- Self-esteem and risk taking
- Perception of risk
- Passing and taking risks in order to pass
- Disclosure and anonymous sex
- Injection drug use

Prevention

- Lack of appropriate FTM specific information
- Surgical status and prevention messages
- TransProtection prevention flyer

Services



- Not FTM specific
- New guys awareness of services
- Few agencies have providers prepared to deal with FTMs
- Fewer agencies have FTMs on staff in direct service positions
- Even for agencies who do have trans specific services, the services are primarily geared for MTFs
- When accessing other services - can't be out as FTM
- Needle access - hormone needles at women and MTF only site



Transgender Community Health Project

Referrals

Problems, Solutions, & Referral Success

Problems

- Lack of information about transgender-sensitive services
- Lack of sensitive services

Solutions

- Developed Trans-Services
- Developed TransProtection
- Developed referral system with information about non-TG specific services
- In-Service Trainings
- HIV Positive Packets

How Referrals Worked

- Interviewer noted emerging issues
- Interviewer addressed emergent issues
- Interviewer asked about other issues or services
- Interviewer made referrals or sent client to Ari
- Ari researched any further services
- During follow-up interviewer asked about referral success and made new referrals

Most common referrals (TCHP could accomodate)

- Transgender Support Groups
- Hormone Health Care
- Job Training
- Crisis Mental Health Services
- Needle Exchange (among drug users)
- Dental Care
- Discrimination

Common Referrals (TCHP couldn't accomodate)

- Permanant Housing
- Mental Health (Non-Crisis)
- Job Placement
- Sex Work Support

Attachment No. 2

"Process Evaluation - HPPC Members Background Experiences Presentation Overheads."
Pages 1 through 4

San Francisco HIV Prevention Community Planning
Year 4 Process Evaluation

Background Experiences of Council Members
December 1997

A lot - A Great Deal of Experience	
84%	Providing HIV education or prevention programs
80%	Losing an acquaintance to AIDS
79%	Productive large group discussions
78%	Working with multicultural peers and colleagues
76%	Supervising or managing HIV education or prevention
75%	Advocating for a group I belong to or care about
75%	Speaking up in large groups
74%	Working with multicultural client or patient populations
72%	Losing a colleague or friend to AIDS
71%	Productive large group decision-making

Not Much - No Experience	
88%	Conducting HIV/AIDS biological research
87%	Statewide HIV prevention planning
69%	Nationwide HIV prevention planning
60%	Providing clinical services to people with HIV/AIDS
50%	Collecting epidemiological data
49%	Reviewing grant proposals
48%	Working with City Hall, the Mayor, or the Health Commission
48%	Monitoring/evaluating cultural competence of programs or agencies

Experience.....

Monitoring/evaluating cultural competence of programs or agencies

13% a great deal or a lot

39% some

48% not much or none

Working with the press and media

30% a great deal or a lot

44% some

26% not much or none

Public speaking (speeches, radio, TV)

52% a great deal or a lot

26% some

21% not much or none

City level policy development or advocacy

48% a great deal or a lot

22% some

30% not much or none

City level prevention planning

39% a great deal or a lot

35% some

26% not much or none

Working with City Hall, the Mayor, or the Health Commission

31% a great deal or a lot

22% some

48% not much or none

Experience.....

Chairing a meeting

62% a great deal or a lot

17% some

23% not much or none

Chairing a committee

54% a great deal or a lot

14% some

32% not much or none

Robert's Rules (Parliamentary Procedure)

40% a great deal or a lot

30% some

30% not much or none

Other offerings....

Great deal of experience:

clinical psychology - private practice

working with youth

developing RFPs

written communication

facilitating Strategic Plan

visioning HIV prevention in the future

coalition building with neighborhood groups, labor unions, etc.

A lot of experience:

single parenting

gay parenting

networking with agencies

working with youth/young adult issues and concerns

Plus.....

4 good listeners

4 cooks + award winning chef

3 poets + children's book author

Play director, art director

2 good travelers, 1 good traveling companion

Pine needle baskets, drawing, growing plants and flowers

Traditional drumming and singing, cha-cha dancing, sex (2), bowling, Giants fan

Driving, full-body massage

Publishing/design/desktop publishing

Reasoning and analysis, teaching meditation and relaxation, reflection, French

Working independently, good team player, organization, getting things done, multi-tasking

Caring for my dog, working with children, caring for the elderly, relationships

Able to learn anything fast, enormous threshold for discomfort; politics, taking action!

18 December 1997

Dear HPPC Colleagues,

On the occasion of my final HPPC meeting, I wanted to express how much I have enjoyed working with you. We have done some important work over the past two years, and I am impressed with the way the Council and its process have evolved. I'm sorry I didn't get the chance to work more with the new members.

I have recently received a promotion to associate editor in the Department of Treatment Education and Advocacy at the San Francisco AIDS Foundation, where I am on the editorial team for *BETA* and *Positive News/Noticias Positivas.* This is a good opportunity for me, but does not leave me with as much time as I feel I would need to continue my participation on the Council.

As many of you know, I am also a journalist and write for several publications including the *Bay Area Reporter.* I've heard many criticisms over the years about how poorly the press covers HIV/AIDS-related issues. I hope that with my knowledge and experience in both the prevention and treatment areas, I will be able to provide intelligent and accurate coverage of the issues we face. In this capacity, you will likely be seeing me at various community meetings and events, and I welcome your calls or e-mail.

Best wishes in your ongoing efforts to fight HIV/AIDS!

Sincerely,

Liz Highleyman
liz@black-rose.com